

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

8769

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead Rural</b>		c. LENGTH OF STAY IN 1b <b>15 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brick Store Road</b>				d. STREET ADDRESS <b>Brick Store Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>N.</b> Last <b>Allen</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1913</b>		9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assemble Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martins Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Merryman Allen</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-14-1278</b>		17. INFORMANT Address <b>Mrs. Frances Allen Hampstead Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound thru abdomen (suicide)</b> 976x DUE TO (b) <b>Mental Depression</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>18 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot wound thru abdomen</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>pm-8/10/59</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hampstead Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D.D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D.D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						<b>8-11-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grave Run Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward C. Tipton</b>				ADDRESS <b>Hampstead, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

10120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY 10

10120

Name of Deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		Fair	
Residence		Occupation		Cause of Death		Manner of Death		Date of Death	
123 Main St, Albany, NY		Teacher		Heart Disease		Natural		Jan 15, 1950	
Physician		Medical Examiner		Coroner		Jury		Burial	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Signature		Signature		Signature		Signature		Signature	
Date		Time		Place		Witness		Remarks	
Jan 15, 1950		10:00 AM		Home		Dr. J. Smith		No autopsy	

10120

10120

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

Item 18 Film 249 10-7-59 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08730

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Leslie Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		4. DATE OF DEATH <b>August 28 19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/25</b>	
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Hench</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-20-7702</b>	
17. INFORMANT <b>Richard Amos</b>		Address <b>5 Leslie Ave., Baltimore</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Idiopathic myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 31, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook, Towson Inc.</b>		ADDRESS <b>1050 York Rd.</b>	
24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08570

250



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

1

002

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8771 CERTIFICATE OF DEATH									
Reg. Dist. No. 32									
1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>3Y01.4</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>					d. STREET ADDRESS <b>21 NORTH CARROLLTON AVE</b>				
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>HELEN</b> Last <b>ARTHUR</b>					4. DATE OF DEATH Month <b>AUGUST</b> Day <b>24</b> Year <b>1959</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 28, 1925</b>		9. AGE (In years last birthday) <b>33</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WESLEY ARTHUR</b>					14. MOTHER'S MAIDEN NAME <b>NANCY HODGES</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>225-22-3167</b>		17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <b>12 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>APRIL 7, 1955</b> to <b>AUG. 24, 1959</b> , that I last saw the deceased alive on <b>AUGUST 24, 1959</b> , and that death occurred at <b>2 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.					Mt. Wilson, Maryland				
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>					Superintendent				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			22b. DATE THEREOF <b>Aug. 25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Mount, Va.</b>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> <b>4101 E. Diamondson Ave.</b>					ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinas</b>

CERTIFICATE OF DEATH

FILE NO. 10-123

NAME OF DECEASED: [Faint text]

AGE: [Faint text]

SEX: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

DATE OF DEATH: [Faint text]

TIME OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

DATE OF BURIAL: [Faint text]

PLACE OF BURIAL: [Faint text]

SIGNATURE OF REGISTRAR: [Faint text]

DATE OF SIGNATURE: [Faint text]

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
10-123



MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
10-123

8755

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dundalk Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Turner Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>148 Carver Road</u>		d. STREET ADDRESS <u>1 148 Carver Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mittie</u> Middle <u>Bailey</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Isles of White Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Branch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sallie Overby - 148 Carver Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480x Virus pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Influenza</u> DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 days 1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 21 - 59</u> to <u>August 1 - 59</u> , that I last saw the deceased alive on <u>August 1 - 59</u> , and that death occurred at <u>2:40</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Thomas</u>		DATE SIGNED <u>1077 Main St Baltimore 22</u>	
PHYSICIAN'S NAME (Type) <u>H. Thomas M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CC-BY 4.0 International license

8772

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Holly Hill s Manor-531 Stevenson Lane</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Sterling Barnes</b>		4. DATE OF DEATH <b>Aug. 8, 1959</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1969</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Ashland, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eden Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Louise Baird</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
INFORMANT <b>Mrs. Benjamin Amos, Bel Air, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1959</b> , to <b>Aug 8, 1959</b> , that I last saw the deceased alive on <b>Aug 2-59</b> , 19, and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Sawyer</b> M.D.		ADDRESS (Street, city or town, state) <b>4808 Harford Rd</b> DATE SIGNED <b>8/8/59</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER, M.D.</b>		<b>Balto 14-2nd</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/11/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>	22d. LOCATION (City, town, or county) (State) <b>Abingdon Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Rutz</b>		ADDRESS <b>Jarrettville Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanes</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1933

WILLIAM BO

OFFICE OF DEATH

1933

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8773

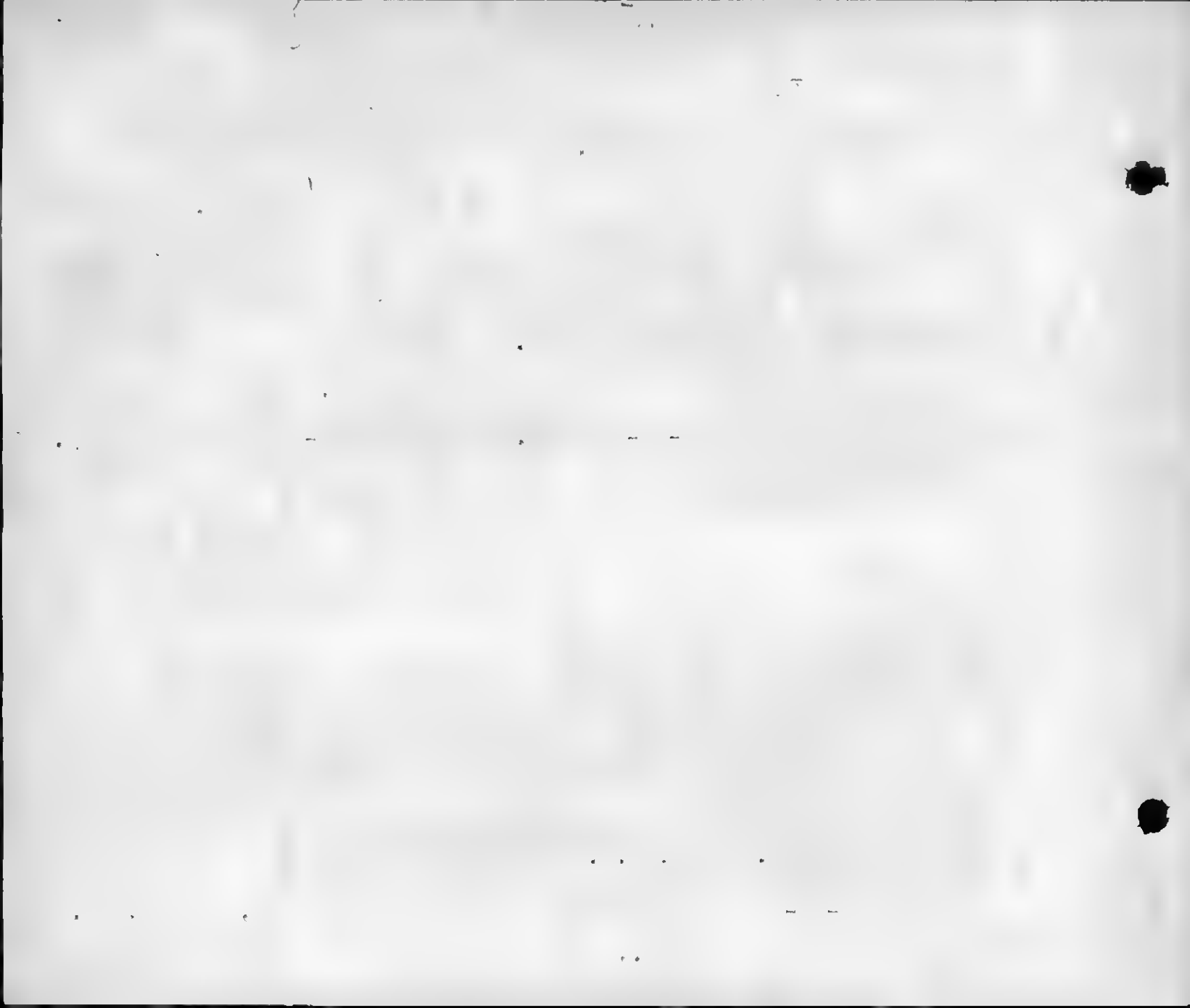
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08734

Reg. Dist. No.

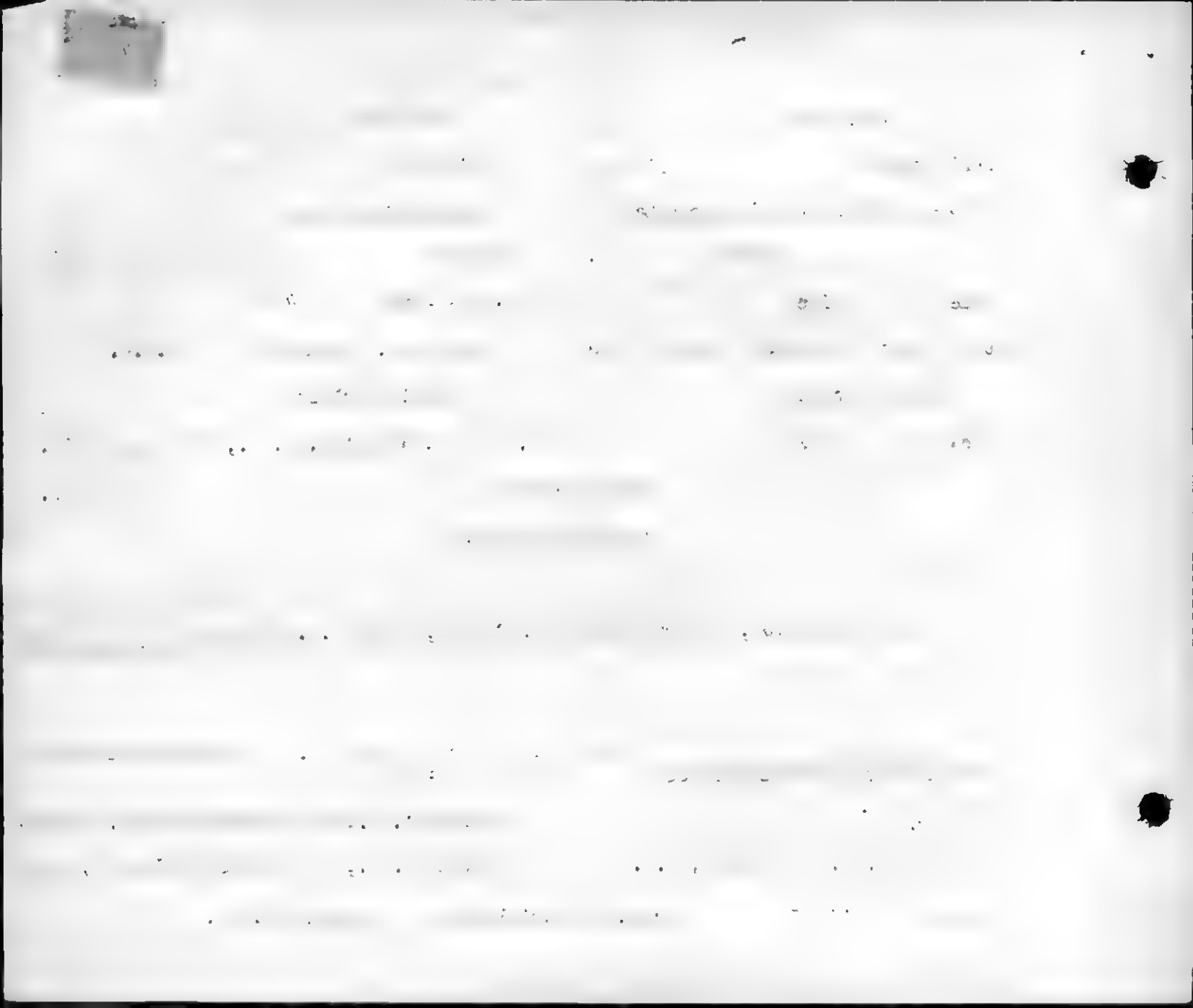
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JOSEPH BARNES</b>		4. DATE OF DEATH <b>August 7, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 22, 1893</b>
9. AGE (In years last birthday) <b>66 1/2</b>		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> IF UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>	
11a. USUAL OCCUPATION (Give kind of work done during week before death, or if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
<b>Bookbinder</b>		<b>Printing Indust.</b>	
13. FATHER'S NAME <b>Joseph Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Quirk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-03-0132</b>	
17. INFORMANT <b>Mr. Norman Barnes</b>		Address <b>3442 Liberty Pkwy. 22</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED <b>White</b> <input type="checkbox"/> <b>Not white</b> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M B Davis M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURYAL (Type) <b>Burial</b>		22b. DATE THEREOF <b>8-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley Inc., Dundalk</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8774 CERTIFICATE OF DEATH													
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>						c. LENGTH OF STAY IN 1b <b>17 days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>H.</b> Last <b>BASEHART</b>						4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1959</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 31, 1887</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Owner &amp; Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Malt &amp; Hops</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Basehart</b>						14. MOTHER'S MAIDEN NAME <b>Mattie Vosburg</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>						16. SOCIAL SECURITY NO <b>XXXXXXXX</b> Address <b>Clin. Records, VAH, Balto. 18, Md., Fort Howard Div.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>46.5 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY EMBOLISM</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS, CEREbro-VASCULAR ACCIDENT, UPPER G.I. BLEEDING</b> INTERVAL BETWEEN ONSET AND DEATH <b>15-20 min.</b>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>(SOURCE UNDETERMINED)</b>													
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>August 7, 1959</b> to <b>August 24, 1959</b> and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. MD., FORT HOWARD DIVISION 8/24/59</b> ACTUAL SIGNATURE <b>W. J. PIJANOWSKI</b> M.D. <b>VAH, BALTO. MD., FORT HOWARD DIVISION 8/24/59</b> PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b> <b>VAH, BALTO. MD., FORT HOWARD DIVISION 8/24/59</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Parcville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR DATE <b>AUG 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>					

LEONARD RUCK & SONS, 5305 Harford Rd Balto Md





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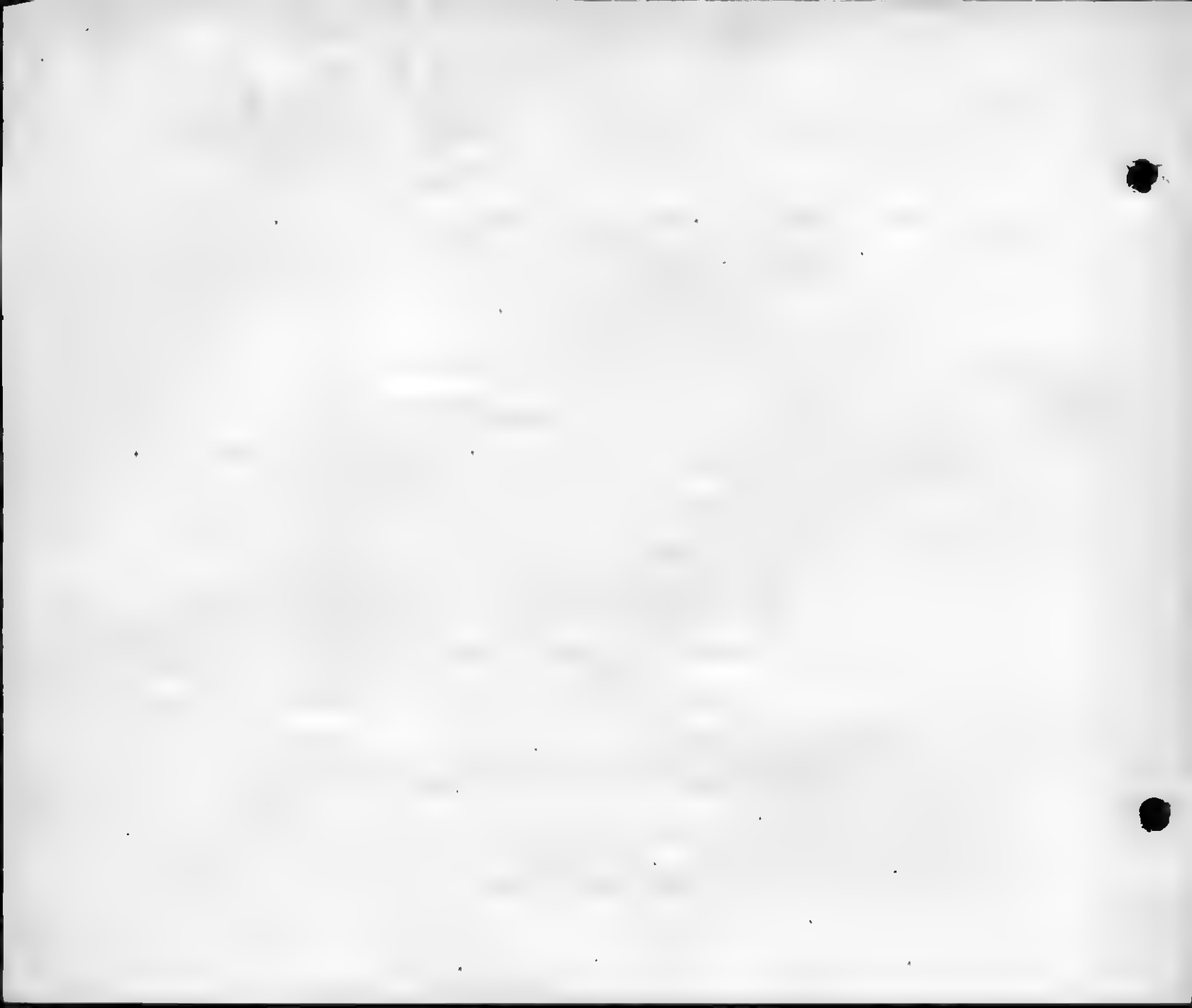
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2031 Russell Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> d. STREET ADDRESS <b>2031 Russell Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nettie M. Bell</b> First Middle Last		4. DATE OF DEATH <b>August 1, 1959</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Milton Reed</b>	
14. MOTHER'S MAIDEN NAME <b>Susanna White</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Lula B. Mills 2031 Russell Ave. 7</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>122.2</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Degenerative Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 1/2 hrs</b>
21. I certify that I attended the deceased from <b>7/31, 1959</b> to <b>8/1, 1959</b> , that I last saw the deceased alive on <b>7/31, 1959</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>		ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD BALTO. 7, MD</b>	
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b>		DATE SIGNED <b>8/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 5 '59</b>	
ADDRESS <b>6411 Windsor Mill Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8776

## CERTIFICATE OF DEATH

06737

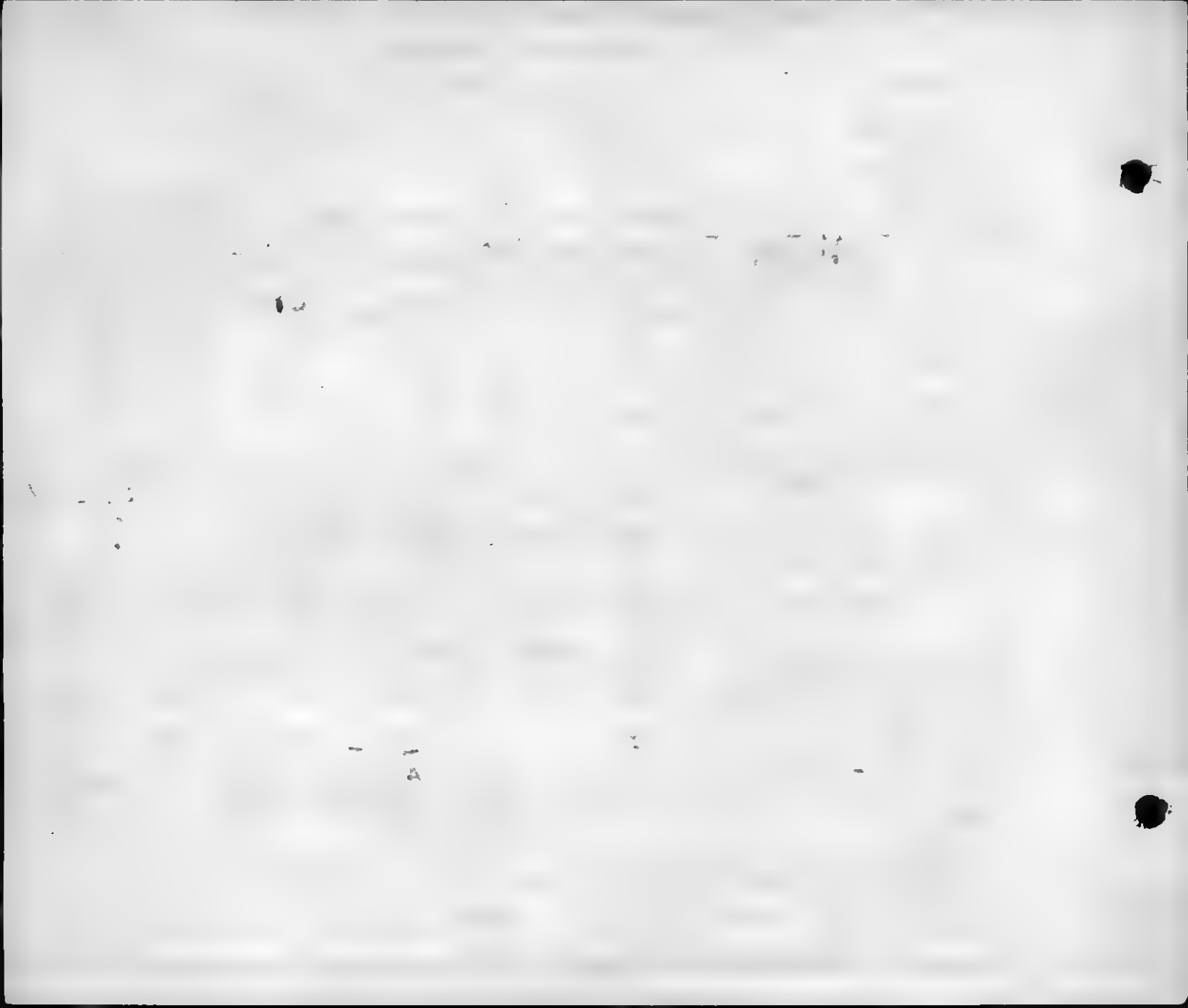
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7841 OAKDALE Ave.</b>		d. STREET ADDRESS <b>7841 OAKDALE AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>ELMER FRANKLIN BENTZ</b>		4. DATE OF DEATH <b>AUG 16 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BENSEL CONTRACTORS</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EARL BENTZ</b>		14. MOTHER'S MAIDEN NAME <b>MARION COOKSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-1069</b>	
17. INFORMANT <b>Mrs. AGNES BENTZ</b>		Address <b>7841 OAKDALE AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 1 1959</b> to <b>AUG 16 1959</b> , that I last saw the deceased alive on <b>AUG 15 1959</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G.M. Baumgardner</b> M.D.		DATE SIGNED <b>8/16/59</b>	
PHYSICIAN'S NAME (Type) <b>G.M. BAUMGARDNER</b>		<b>8552 PHILA. RD. MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/19/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George W. Hoffmann</b>		ADDRESS <b>3218 HUDSON ST.</b>	
24a. REC'D BY REGISTRAR <b>Aug 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kneiss</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

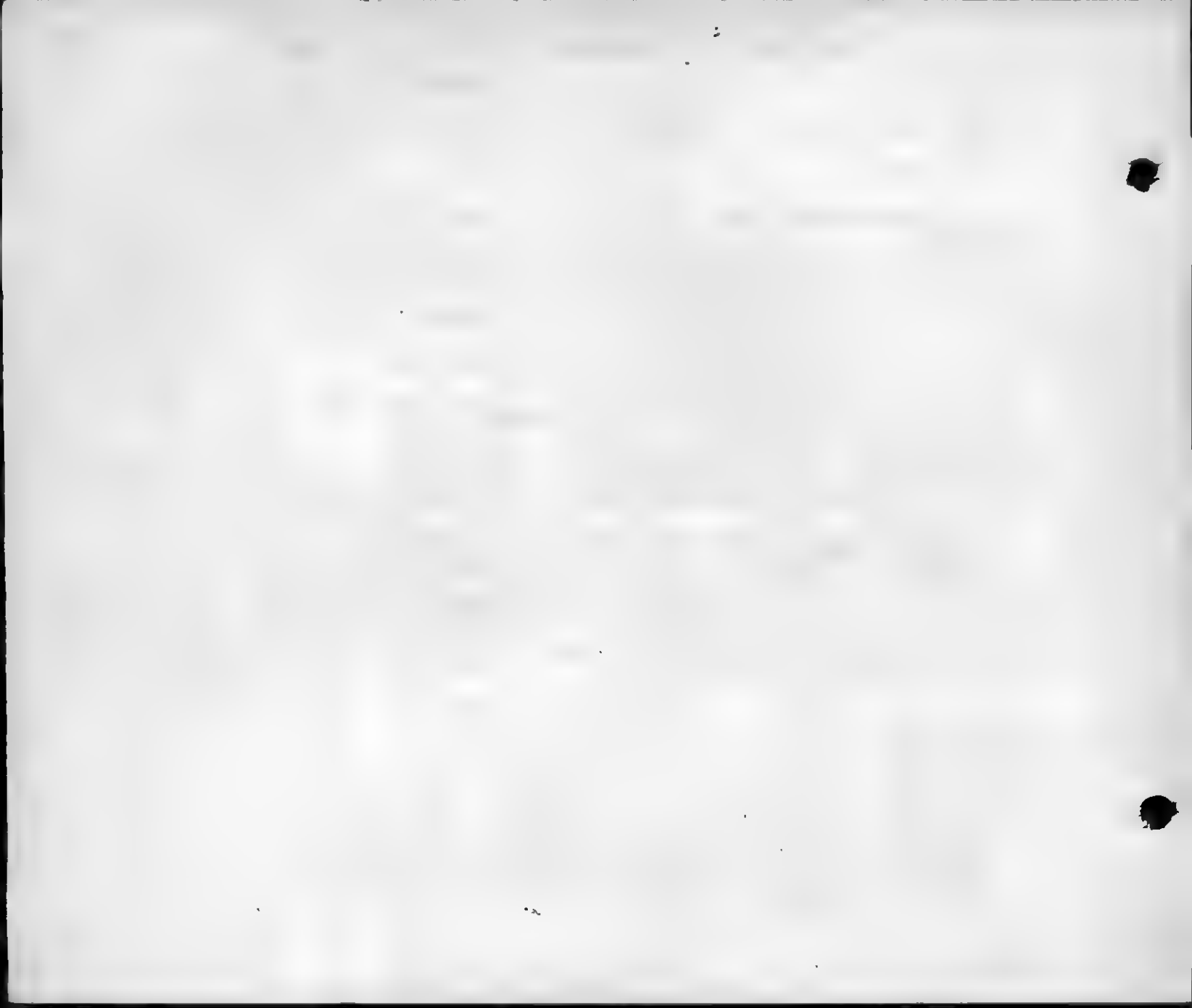
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>613 FRANKLIN AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>M.D.</u> <span style="float: right;">b. COUNTY <u>BALTO</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 ESSEX</u> d. STREET ADDRESS <u>613 FRANKLIN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CHARLES L BETZ</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>AUG. 4 1959</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>AUG 12 - 1877</u>		<b>9. AGE</b> (In years last birthday) <u>81 yrs.</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>PENN R. R.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTO. MD.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b>  			<b>13. FATHER'S NAME</b> <u>JACOB BETZ</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY SCHIRMER</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b>  			<b>17. INFORMANT</b> Address <u>WALTER BETZ 125 STUART (21)</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>ASCVD DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.					
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>W. B. Davis</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>W. B. Davis M.D.</u>			<b>DATE SIGNED</b> <u>8/6/59</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>8/7/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CARL LAWN</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTO. MD.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>John J. Connelly 418 E. ...</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>AUG 11 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. ...</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8778

## CERTIFICATE OF DEATH

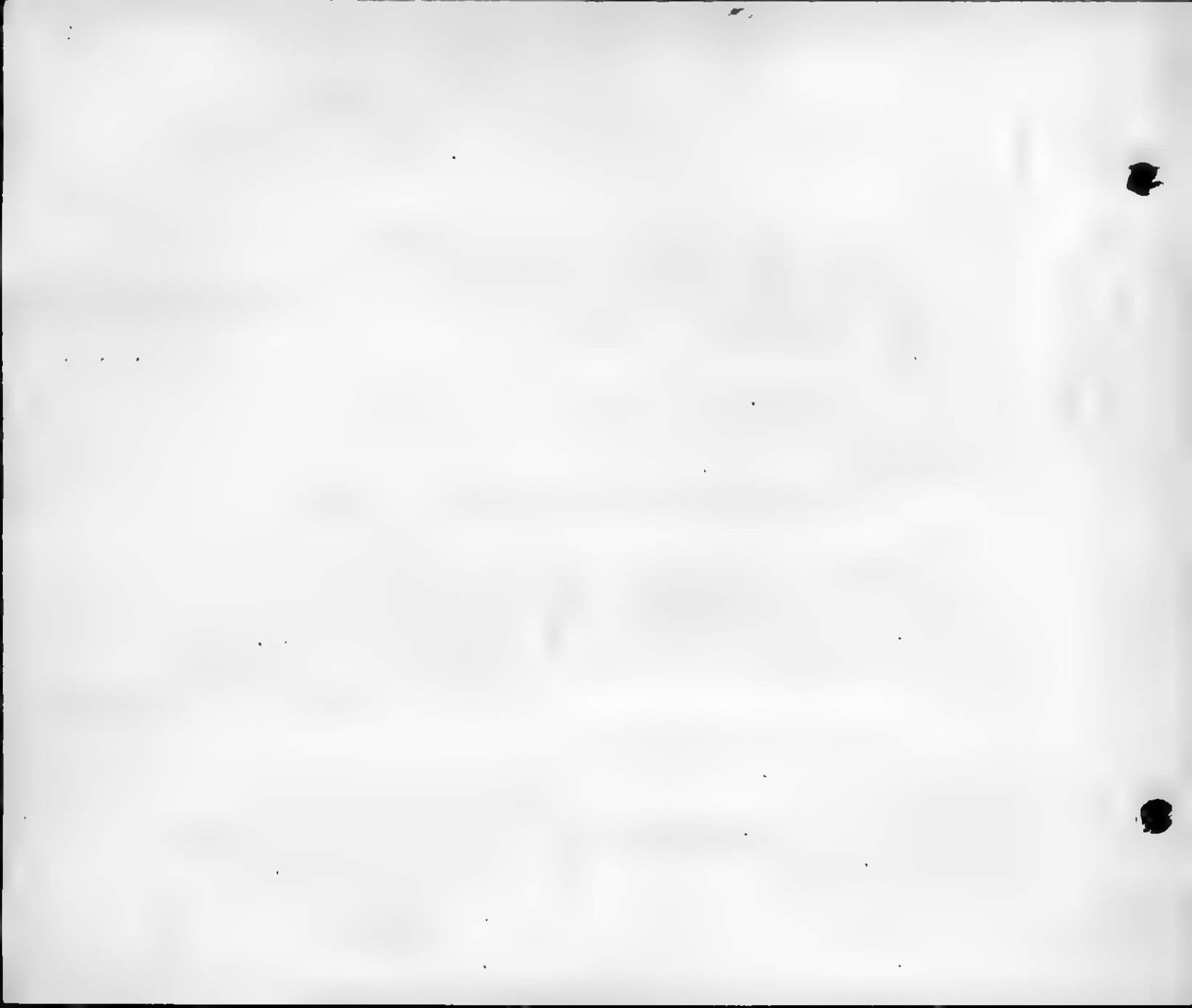
08739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>11yr4mth6dys</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>52 Spring Street</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b> First Middle Last <b>Bicchiri</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1905</b> 9. AGE (In years, last birthday) <b>54</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Antonia Bicchiri</b>		14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Accident</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>20 days</b> <b>Several yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Diabetes Mellitus</b> <b>2. Benign Prostatic Hypertrophy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July 27, 1959</b> to <b>August 18, 1959</b> , that I last saw the deceased alive on <b>August 17, 1959</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>8-18-59</b>		
ACTUAL SIGNATURE <b>Edward T. Schmor</b> M.D.		
PHYSICIAN'S NAME (Type) <b>Edward T. Schmor, M.D.</b>		<b>Catonsville 28, Maryland</b>
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
<b>Burial</b>	<b>8/19/59</b>	<b>Catholic</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Stoney &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>
ADDRESS <b>1318 Light St</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8779

## CERTIFICATE OF DEATH

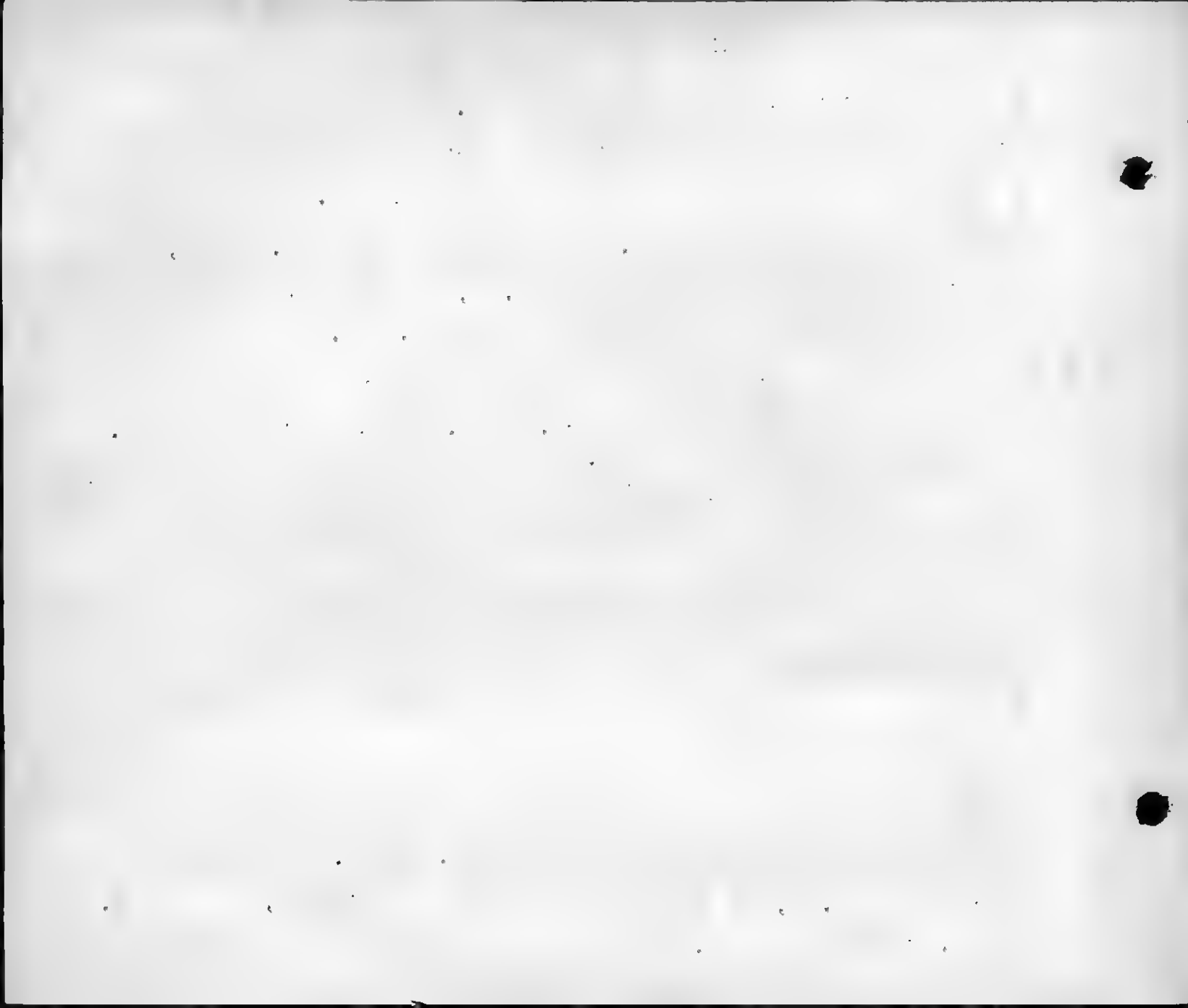
08740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>House in The Pines</b>		d. STREET ADDRESS <b>4332 Roland Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>L.</b> Last <b>Bird</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1872</b>
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR: Months <b>8</b> Days <b>10</b> Hours <b>10</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Loudon Co. Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Loudon Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Americas James Souder</b>		14. MOTHER'S MAIDEN NAME <b>Jane Frazier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1-1-1-1-1-1-1-1-1-1</b>	
17. INFORMANT <b>Mrs. Jane B. Worthington</b>		Address <b>4332 Roland Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> DUE TO <b>art. scl. cv disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>art. scl. cv disease</b> (c) <b>art. scl. cv disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan. 1950</b> to <b>8/20, 1959</b> , that I last saw the deceased alive on <b>8/18, 1959</b> , and that death occurred at <b>7:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 E. Read St. Balto Md</b> DATE SIGNED <b>Arthur L. Thomas</b>			
ACTUAL SIGNATURE <b>R. Maurice Feldman M.D.</b>			
PHYSICIAN'S NAME (Type) <b>2 E. Read St. Balto Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>Aug 24 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on all completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

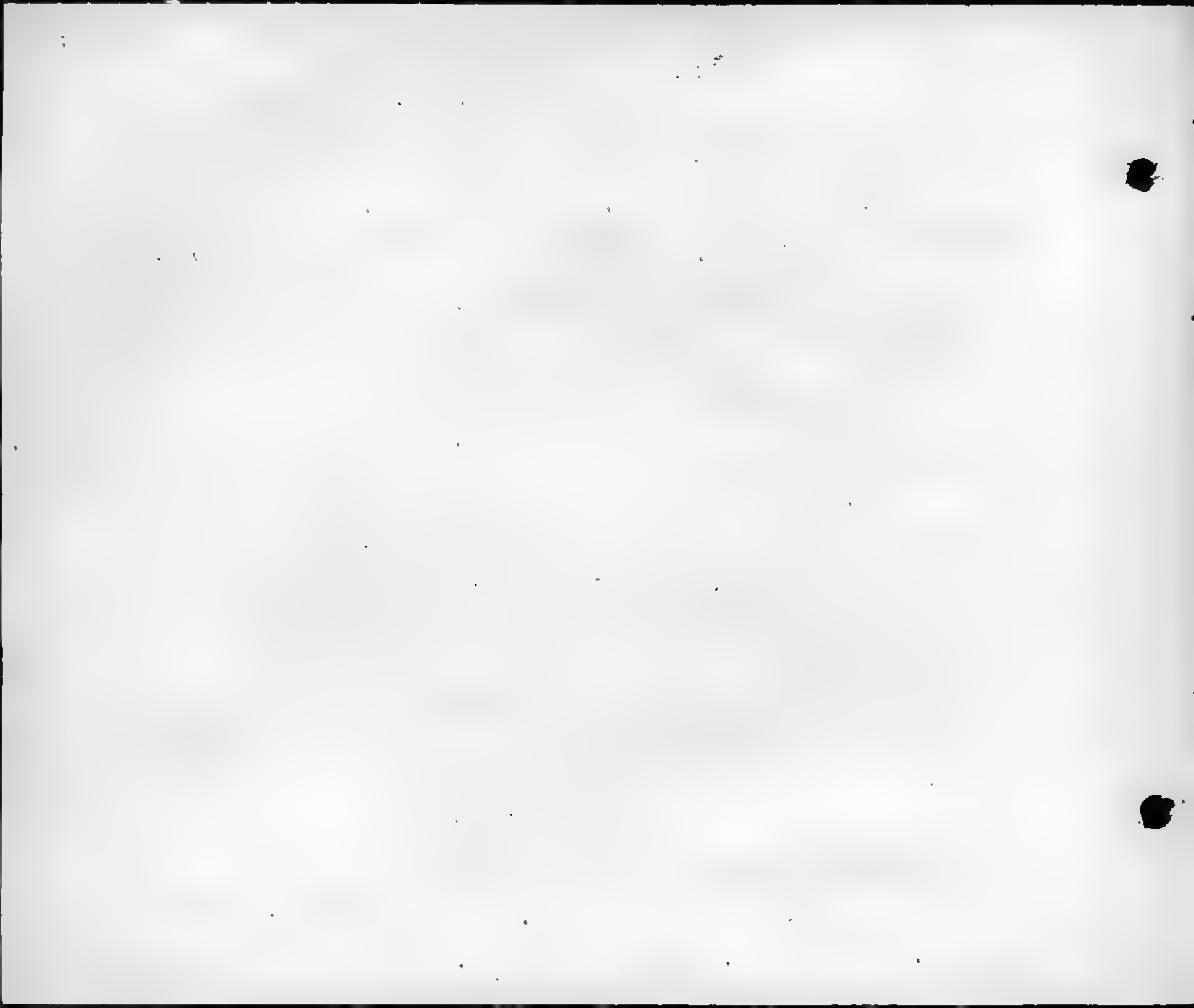
8780

## CERTIFICATE OF DEATH

08741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>V</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crocker Farm, Ridge Rd.</i>		c. LENGTH OF STAY IN lb <i>4 mths</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crocker Farm, Ridge Rd.</i>		d. STREET ADDRESS <i>4830 Kurtz Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>B.</i> Last <i>Blades</i>		4. DATE OF DEATH Month <i>August</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 19, 1878</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR: Months <i>83</i> Days <i>X</i> Hours <i>3</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Charles McClain</i>		14. MOTHER'S MAIDEN NAME <i>Mattie Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give year or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Charles E. McClain</i>		Address <i>4830 Kurtz Rd, McClain, Va.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>HYPERTENSIVE - ARTERIOSCLEROTIC C.V.</i> DUE TO (c) <i>DISEASE WITH CARDIAC DECOMPENSATION</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 HRS.</i>  <i>3 YRS</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>MAY 15TH, 1956</i> to <i>AUGUST 29, 1959</i> , that I last saw the deceased alive on <i>AUGUST 29, 1959</i> , and that death occurred at <i>6:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Martin E. Strobel</i>		ADDRESS (Street, city or town, state) <i>48 MAIN ST. FEISTERSTOWN</i>	
PHYSICIAN'S NAME (Type) <i>MARTIN E. STROBEL</i>		DATE SIGNED <i>8/29/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 1, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemt.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>		ADDRESS <i>3000 E. Baltimore St, Balto.</i>	
24a. REC'D BY REGISTRAR <i>SEP 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Ortner &amp; Hanna</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

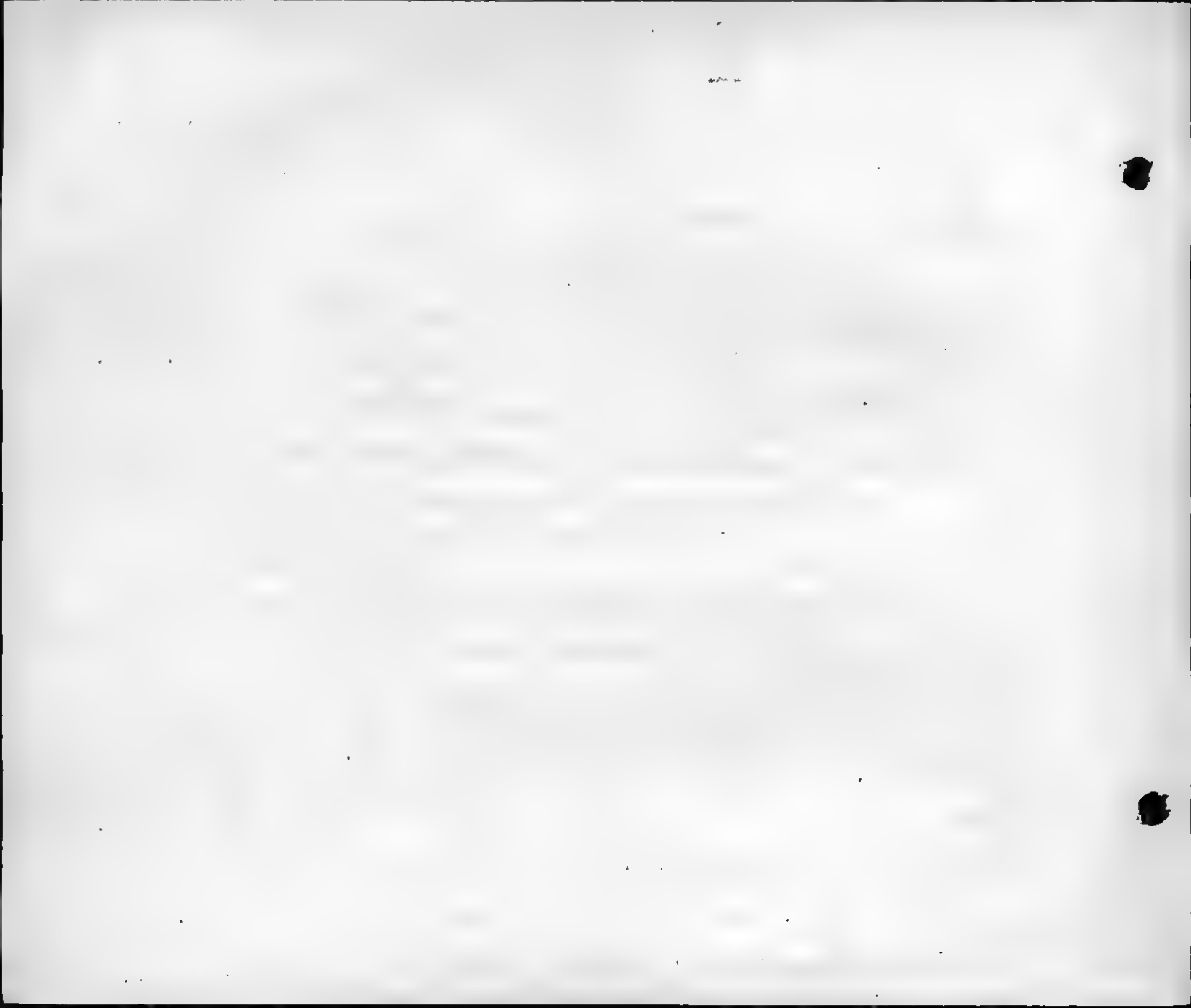
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8781 CERTIFICATE OF DEATH

08742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth4d6s</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>5806 - 33rd Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Bodkin</b> Last <b>Bodkin</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	11. IF UNDER 24 HRS Months <b>11</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired B &amp; O Railroad Terminal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph B. Bodkin</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Cutlip</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 24, 1959</b> to <b>Aug. 28, 1959</b> , that I last saw the deceased alive on <b>Aug. 28, 1959</b> , and that death occurred at <b>9:00a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 8-28-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 31, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gracis Sons</b>		24a. REC'D BY REGISTRAR <b>SEP 1 '59</b>	
ADDRESS <b>Gallsoll</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

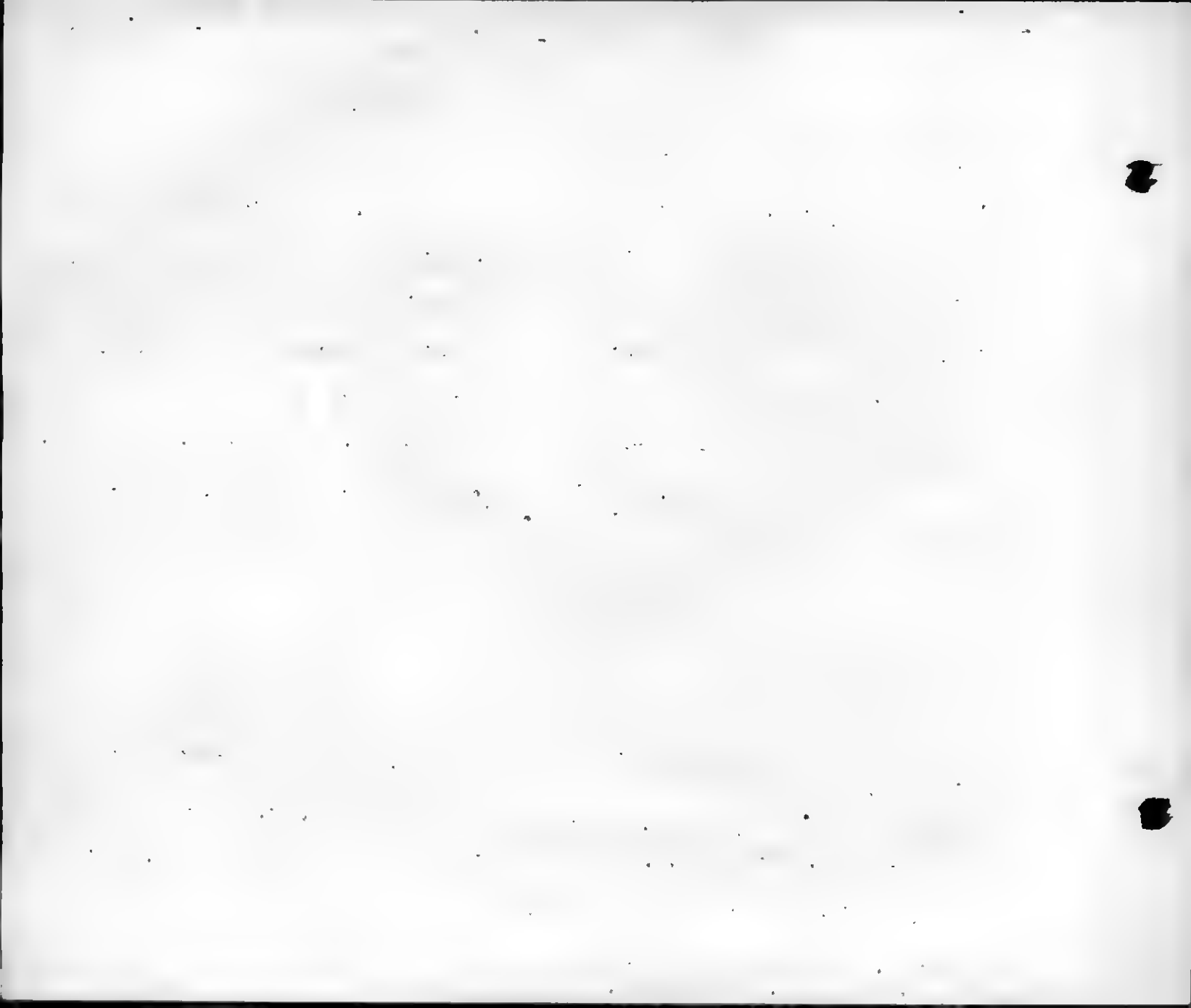
item 9 film 6248 9-11-59 et  
8782 CERTIFICATE OF DEATH

Reg. Dist. No.

05743

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>127 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>633 N. Carrollton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John (None) Booker</b>		4. DATE OF DEATH Month Day Year <b>August 29 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1893</b>
9. AGE (In years last birthday) yrs <b>66 2/3</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>66 2/3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisville, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Booker</b>		14. MOTHER'S MAIDEN NAME <b>Name Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-01-6106</b>	
INFORMANT <b>Clin Records, Vet. Adm Hosp, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT (AREA OF SOFTENING IN THE LEFT PARIETAL LOBE)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24, 1959</b> to <b>August 29, 1959</b> and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>8/29/59</b> ACTUAL SIGNATURE <b>David A. Oursler</b> M.D. <b>DAVID A. OURSLER, M.D.</b> <b>VAH, Fort Howard, Maryland</b> <b>8/29/59</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>	
ADDRESS <b>1808-10 N. Monroe St. Balto 17, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Colin S. Travis</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

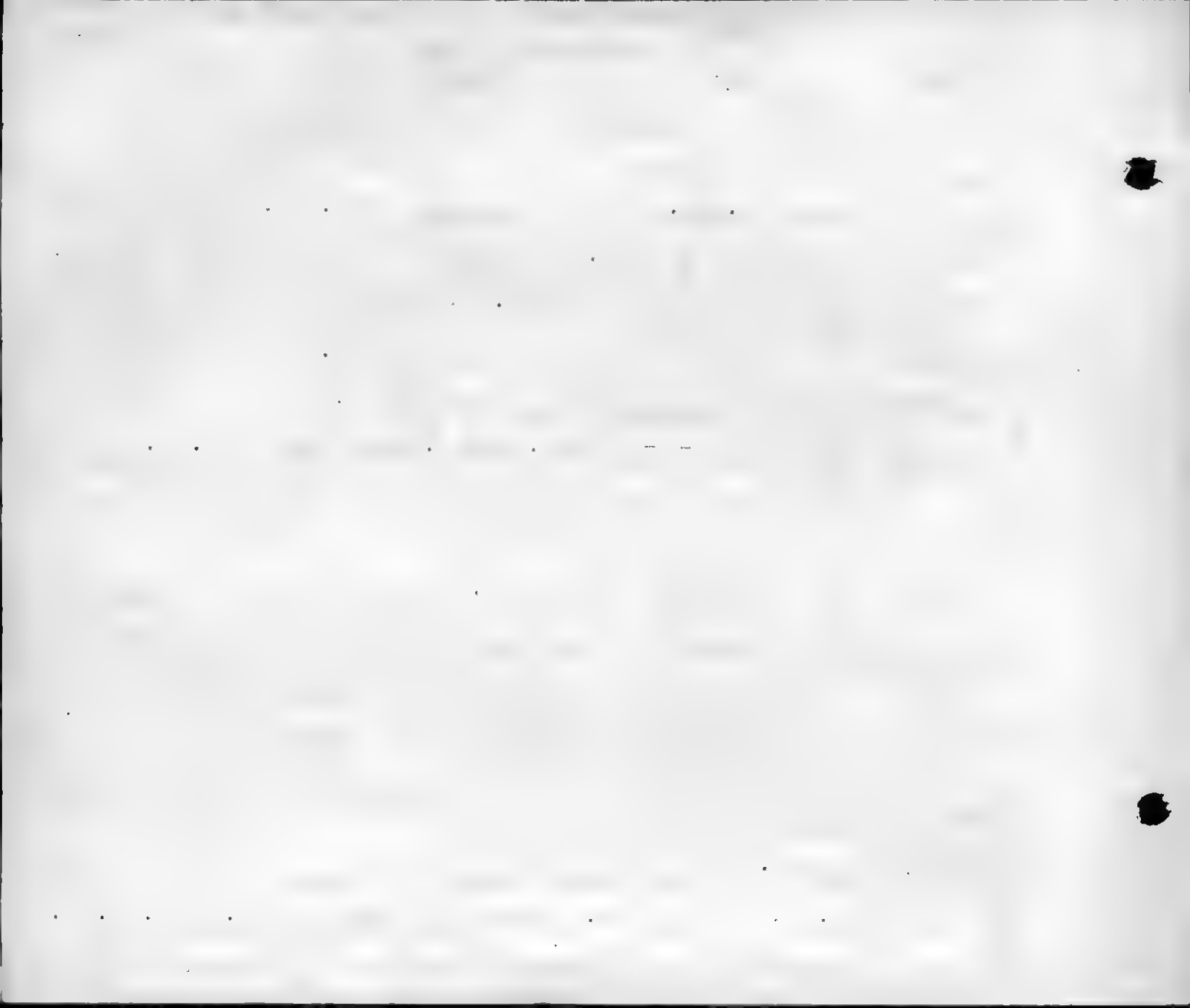
8783

## CERTIFICATE OF DEATH

08744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8419 Phila. Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>E.</u> Last <u>Boone</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager-Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Boone</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-91-9110</u>	
17. INFORMANT <u>Mrs. Ethel J. Boone</u>		Address <u>8419 Phila. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>August 12, 1959</u> to <u>Aug 24, 1959</u> that I last saw the deceased alive on <u>Aug 24, 1959</u> and that death occurred at _____ M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Orth</u> M.D.		ADDRESS (Street, city & town, State) <u>Rosedale Medical Group.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>John G. Orth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 27, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahan Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Aug 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>





8784

## CERTIFICATE OF DEATH

08745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>5 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. STREET ADDRESS <b>1429 ROSEWICK AVE</b>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>B</b> Last <b>BOULDEN</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-16-1879</b>	
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>RICHARD S. HALL</b>				14. MOTHER'S MAIDEN NAME <b>SUSANNAH SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-22-0817</b>		17. INFORMANT <b>Frank X. Smith Jr.</b> Address <b>Cockeysville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> <b>4</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7/29</b> , 1959, to <b>8/11</b> , 1959, that I last saw the deceased alive on <b>8/11</b> , 1959, and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D. <b>Cockeysville, Md</b>				<b>8/11/59</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Freeland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Freeland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8762

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08746

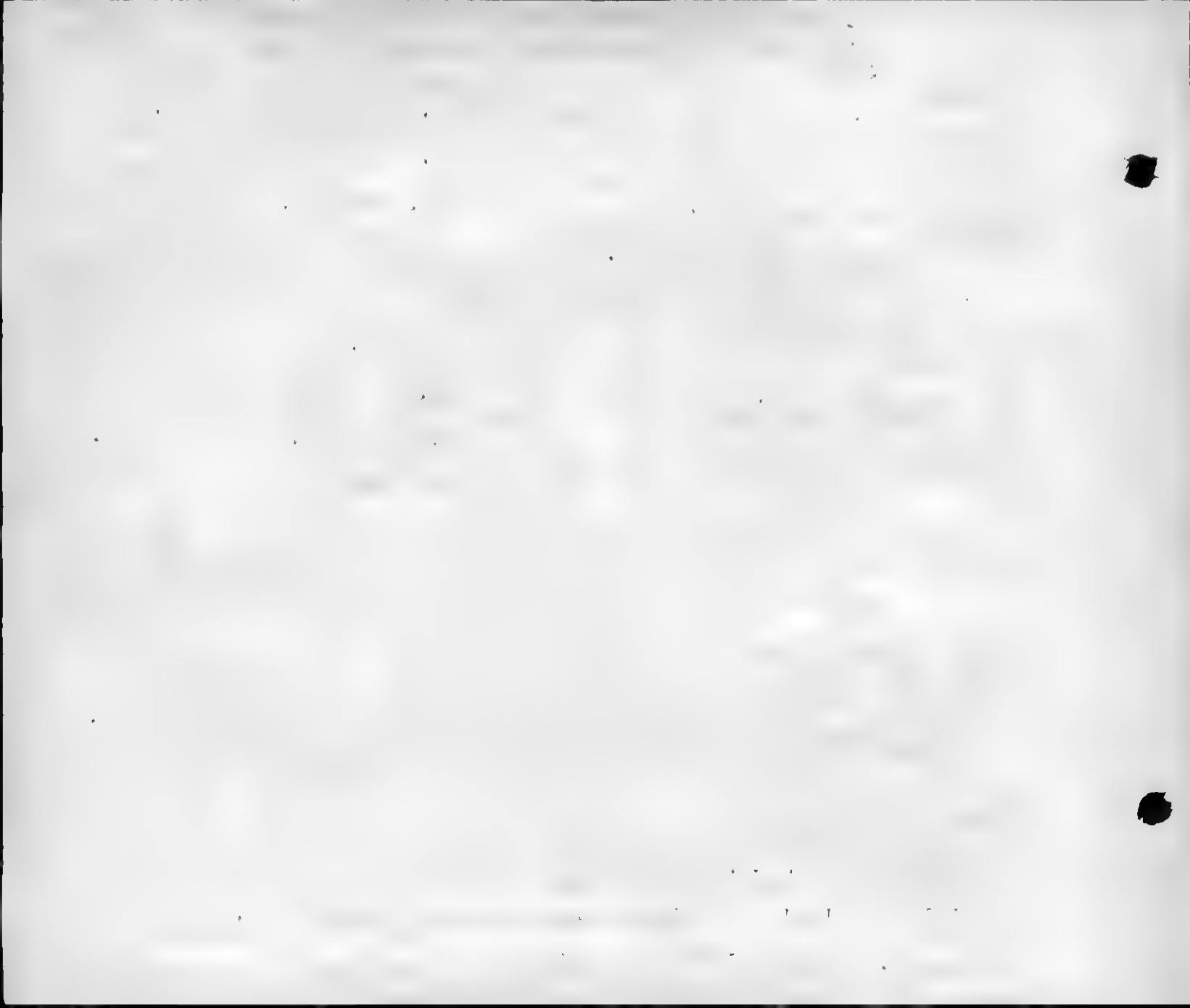
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blue Dam Lake Benson Ave.</u>			d. STREET ADDRESS <u>1420 Mt. Royal Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Thurman</u> Middle <u>R. Bozeman</u> Last <u>Jr.</u>			4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/44</u>	9. AGE (In years last birthday) <u>15</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Portsmouth Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thurman Bozeman Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Cleo XXXXX Dorothy Weber</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thurman R. Bozeman Sr. Portsmouth, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning while swimming</u> 729.8 DUE TO <u>accident</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>while swimming in lake</u>			
20c. TIME OF INJURY Month, Day, Year <u>8/26/59</u> Hour <u>10</u> : <u>20</u> pm 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>lake</u>		20f. (City or town) (County) (State) <u>Arbutus, Balto, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Dr. Geo. S.M. Kieffer, MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/27/59</u>	
EXAMINER'S NAME (Type) <u>Dr. Geo. S.M. Kieffer, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Portsmouth, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>			24a. REC'D BY REGISTRAR <u>SEP 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kieffer</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8785

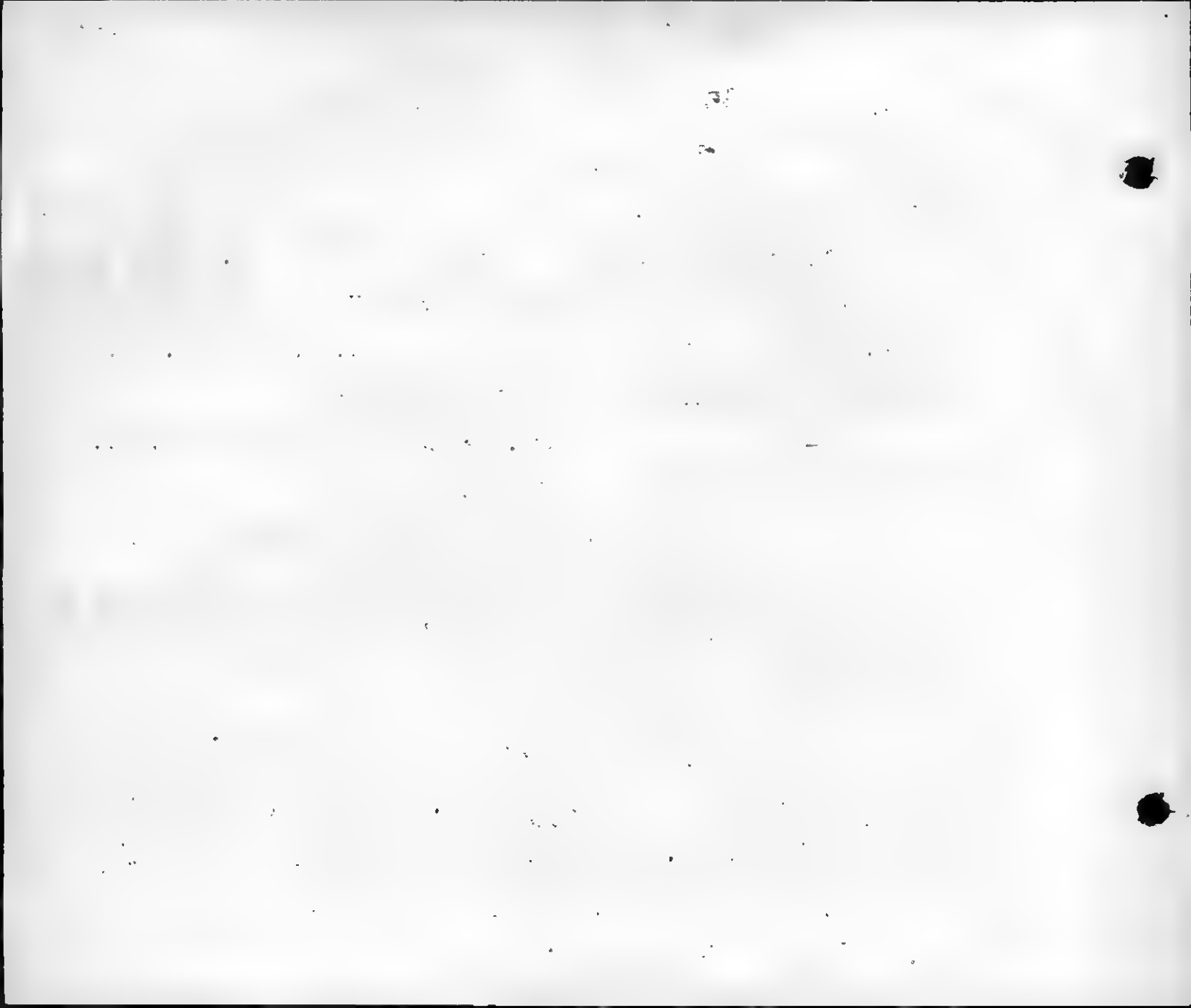
CERTIFICATE OF DEATH

Reg. Dist. No.

08747

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jarrettsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Nelson Brown</b>		4. DATE OF DEATH Month Day Year <b>Aug. 24, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 24, 1887</b>
9. AGE (in years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Jarrettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Watters Amoss</b>		14. MOTHER'S MAIDEN NAME <b>Laura Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>-----</b> INFORMANT Address <b>Mrs. Lee Kee Jarrettsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARKINSONISM; MALNUTRITION</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 22, 1959</b> to <b>Aug 24, 1959</b> that I last saw the deceased alive on <b>Aug 21, 1959</b> and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. V. Harbold</b>		ADDRESS (Street, city or town, state) <b>4706 Harford Rd. Md.</b> DATE SIGNED <b>Aug 24, 1959</b>	
PHYSICIAN'S NAME (Type) <b>H. V. HARBOLD M.D.</b>		<b>Baltimore-14, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/27/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jarrettsville</b>	22d. LOCATION (City, town, or county) (State) <b>Jarrettsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kutz</b> ADDRESS <b>Jarrettsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8786

## CERTIFICATE OF DEATH

Reg. Dist. No.

08748

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		d. STREET ADDRESS <b>8 Park Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah C. Brown</b>		4. DATE OF DEATH Month Day Year <b>Aug 31 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY:	
13. FATHER'S NAME <b>George R. Curtis</b>		14. MOTHER'S MAIDEN NAME <b>N May Marchant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Jos. D. Brown</b>		Address <b>8 Park Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Interstitial Nephritis</b> DUE TO (c) <b>Carcinoma of Cervix</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>3 months</b> <b>18 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1955</b> to <b>Aug 31, 1959</b> , that I last saw the deceased alive on <b>Aug 31, 1959</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Dr. A. Kochman</b> M.D.		ADDRESS (Street, city or town, state) <b>1214 N. Calvert St. Balto</b> DATE SIGNED <b>9/1/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. A. Kochman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		ADDRESS <b>Catonsville Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8787 CERTIFICATE OF DEATH

08749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGIE EHRMAN BURKE</b>		4. DATE OF DEATH Month Day Year <b>AUG. 22 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-1877</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE M. EHRMAN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH M. EICHLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiac</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 23, 1959</b> , to <b>Aug 22, 1959</b> , that I last saw the deceased alive on <b>Aug 21, 1959</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D.		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>8/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>		<b>Cockeysville, Md.</b> <b>8/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>AUG 25 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8788 CERTIFICATE OF DEATH

08750

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>2 wks</u>				d. STREET ADDRESS <u>1403 John St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5743 EDMONDSON AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILHELMINA P. BURROWS</u>				4. DATE OF DEATH <u>Aug 27 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE'S AID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WOMEN'S Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CARL J Losch</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FAMILY RECORDS</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 19 1959</u> to <u>Aug 27 1959</u> that I last saw the deceased alive on <u>Aug 26 1959</u> , and that death occurred at <u>3:14 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles F. Evans</u> M.D.				23. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			
PHYSICIAN'S NAME (Type)				24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES F. EVANS + SON</u> ADDRESS <u>118 W. Mt. Royal AVE</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8789

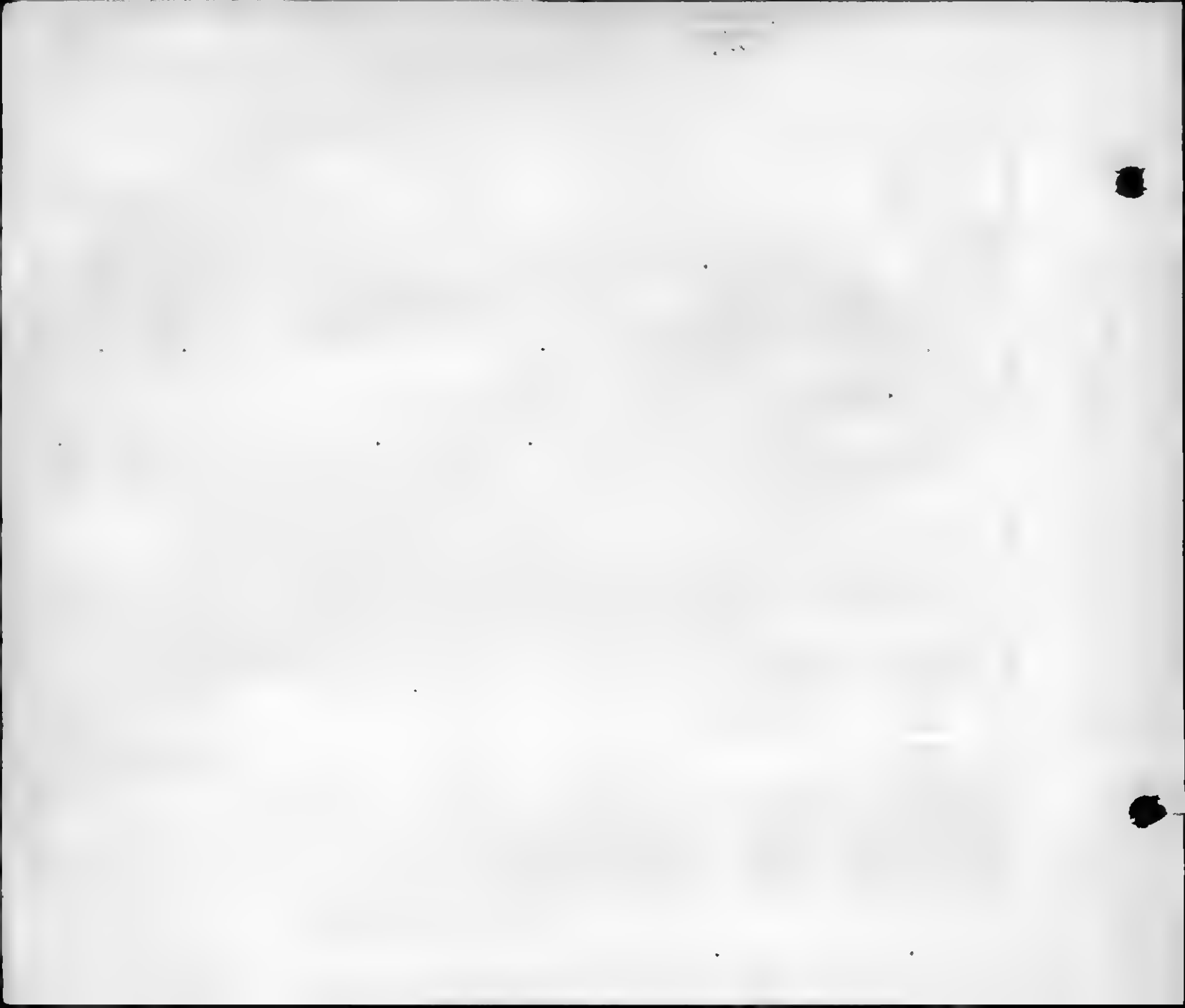
## CERTIFICATE OF DEATH

Reg. Dist. No.

08751

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Holly Hill Nursing Home</b>		e. STREET ADDRESS <b>3932 Lowndes Avenue</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James A. Cain</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1959</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1874</b>	9. AGE (In years last birthday) <b>85</b>	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		11. IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Investment Co. Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James A. Cain</b>		14. MOTHER'S MAIDEN NAME <b>Ann O'Dowd</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mrs. Marjory C. Cain-3932 Lowndes Ave.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease with Decompensation</b> 412.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disc</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>19 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month <b>April</b> Day <b>11</b> Year <b>1947</b> Hour <b>4 P.</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1947</b> to <b>Aug 11, 1959</b> , that I last saw the deceased alive on <b>Aug 11, 1959</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Wm H Kanner</b>		ADDRESS (Street, city or town, state) <b>6011 York Rd. Baltimore Md</b>		DATE SIGNED <b>8/18/59</b>					
PHYSICIAN'S NAME (Type) <b>W</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran-3000 E. Baltimore Street</b>		ADDRESS <b>3000 E. Baltimore Street</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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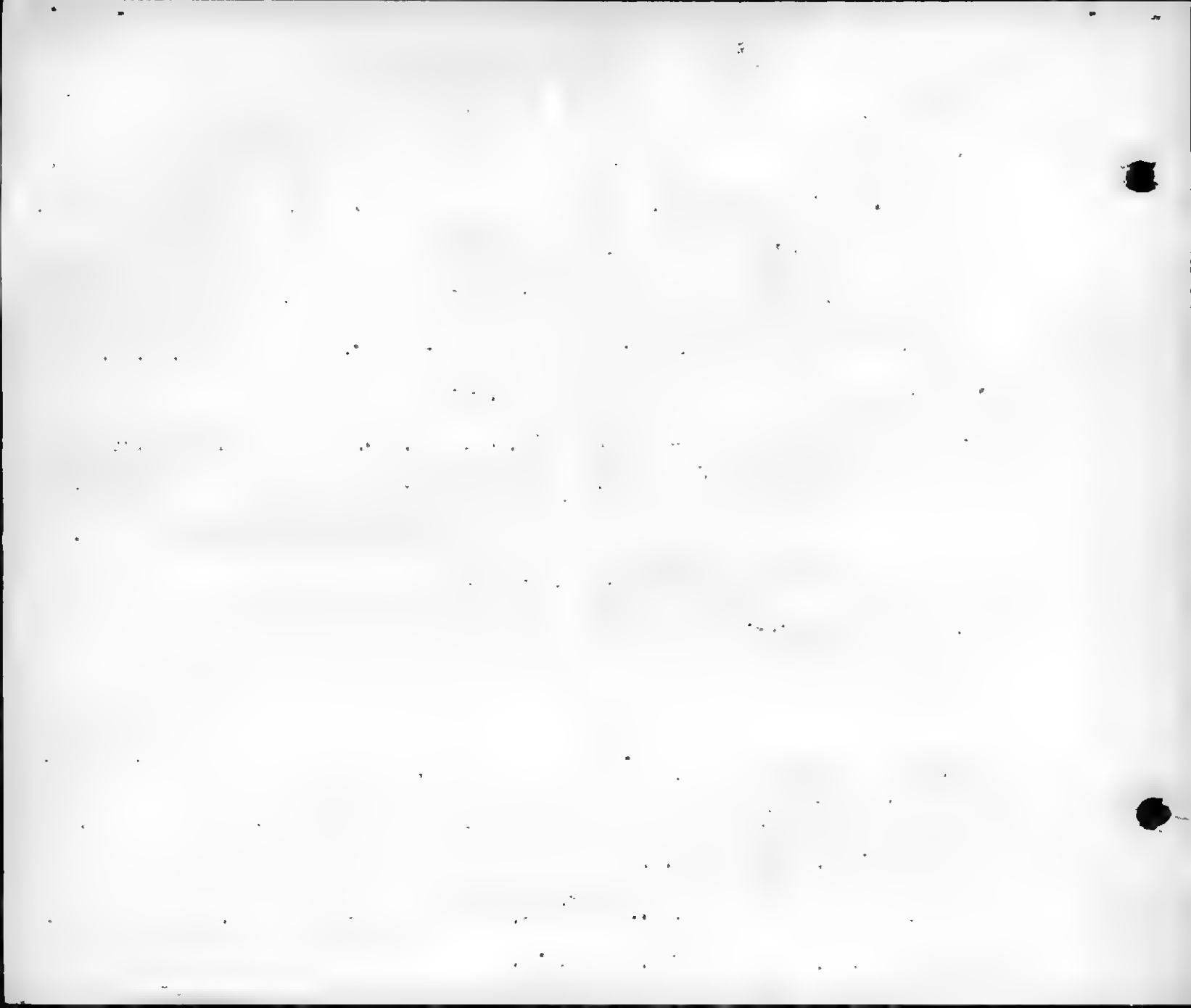
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08752

## 8790 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>28 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3218 Dorithan Road (15)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>--</b> Last <b>CAPLAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1921</b>
9. AGE (In years last birthday) <b>38</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>15</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Max Caplan</b>		14. MOTHER'S MAIDEN NAME <b>Sara Zabolnski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>217-26-4804</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA, SIGMOID COLON</b> 153.3 <b>XXXX</b> METASTATIC ADENOCARCINOMA, LIVER AND RETROPERITONEAL 6 MONTHS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LYMPH NODES</b> (c) <b>PULMONARY EMPHYSEMA, MARKED</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Exploratory Laporatomy; Colostomy 3/29/59</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 13</b> , 19 <b>59</b> , to <b>August 10</b> , 19 <b>59</b> , and that death occurred at <b>10:40 AM</b> , from the causes and on the date stated above. <b>XXXXXX</b> ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>8/10/59</b> ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Maryland Free State Jewish War Vet. Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Hamilton Ave. Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc. 2100 Eutaw Pl., Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 12 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	





8791

## CERTIFICATE OF DEATH

08754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. STREET ADDRESS <u>Box 142-B, Glen Arm, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Lovella</u> Last <u>Christopher</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 11 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Ada L. Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Eugene R. Christopher</u>		Address <u>Glen Arm, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO (c) <u>  </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis Agitans</u> <u>Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>57</u> , to <u>Aug.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 11</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>8-11-59</u> ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY, <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8792

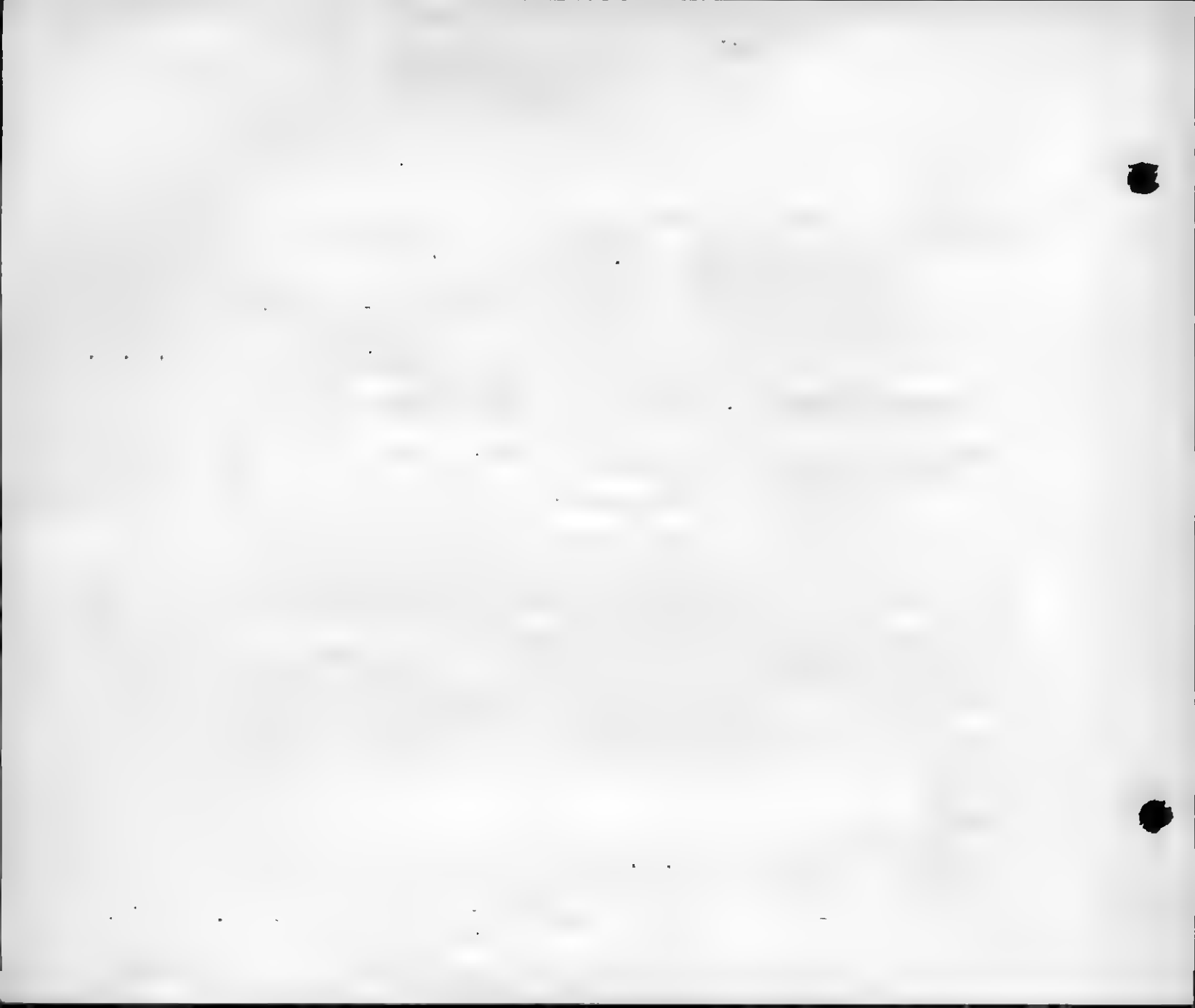
## CERTIFICATE OF DEATH

08755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. STREET ADDRESS <u>6103 Falls Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard C. Cole</u>				4. DATE OF DEATH Month Day Year <u>August 17 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>XXXX 10-22-85</u>		9. AGE (In years last birthday) <u>73 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>XXXXXXXX Howard S. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>XXXXXX no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>7-15-02-4421A</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular thromboses</u> DUE TO (c) <u>Cerebral; generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 mo plus</u> <u>months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary abscesses; unresolved pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 29</u> , 19 <u>59</u> , to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>59</u> , and that death occurred at <u>4:20 p. m.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Butler, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service</u>				ADDRESS <u>Towson 4</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8756

## CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7465 Lawrence Road</b>		e. STREET ADDRESS <b>1930 Robinwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>SHAFFER</b> Last <b>CONLEY</b>		4. DATE OF DEATH Month <b>August 12,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1888</b>
9. AGE (In years last birthday) yrs <b>71</b>		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>59</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Grafton, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William L. Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Born</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>INFORMANT</b> <b>Mrs. Eileen Peters 7465 Lawrence Road</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary metastatic Carcinoma</b> <b>170x</b> DUE TO <b>Carcinoma of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <b>one year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Manh. Day, Year <b>19</b> Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 16 Aug.</b> 1955, to <b>16 Aug.</b> 1959, that I last saw the deceased alive on <b>16 Aug.</b> 1959, and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2900 Dunbar Rd. Md.</b> DATE SIGNED <b>8-17-59</b>			
ACTUAL SIGNATURE <b>Morris Rainess</b> M.D.		22. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS RAINESS, M.D.</b>		22b. REGISTRAR'S SIGNATURE <b>Dundalk 22 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8793

## CERTIFICATE OF DEATH

08757

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7940 Eastern Ave. (24)</u>		d. STREET ADDRESS <u>7940 Eastern Ave. (24)</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>COOPER</u> Last <u>COOPER</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOWMAN (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Omaha, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samson Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Mary Steli</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Pat. Cooper</u>		Address <u>7940 Eastern Ave. (24)</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8-20-59</u> , 19 <u>59</u> , to <u>8-24-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-20-59</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>John L. Outh, M.D.</u>		DATE SIGNED <u>8-24-59</u>
PHYSICIAN'S NAME (Type) <u>John L. Outh</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Grove</u>
22d. LOCATION (City, town, or county) (State) <u>Patterson</u> <u>N. Jersey</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>
ADDRESS <u>418 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8794 CERTIFICATE OF DEATH

08758

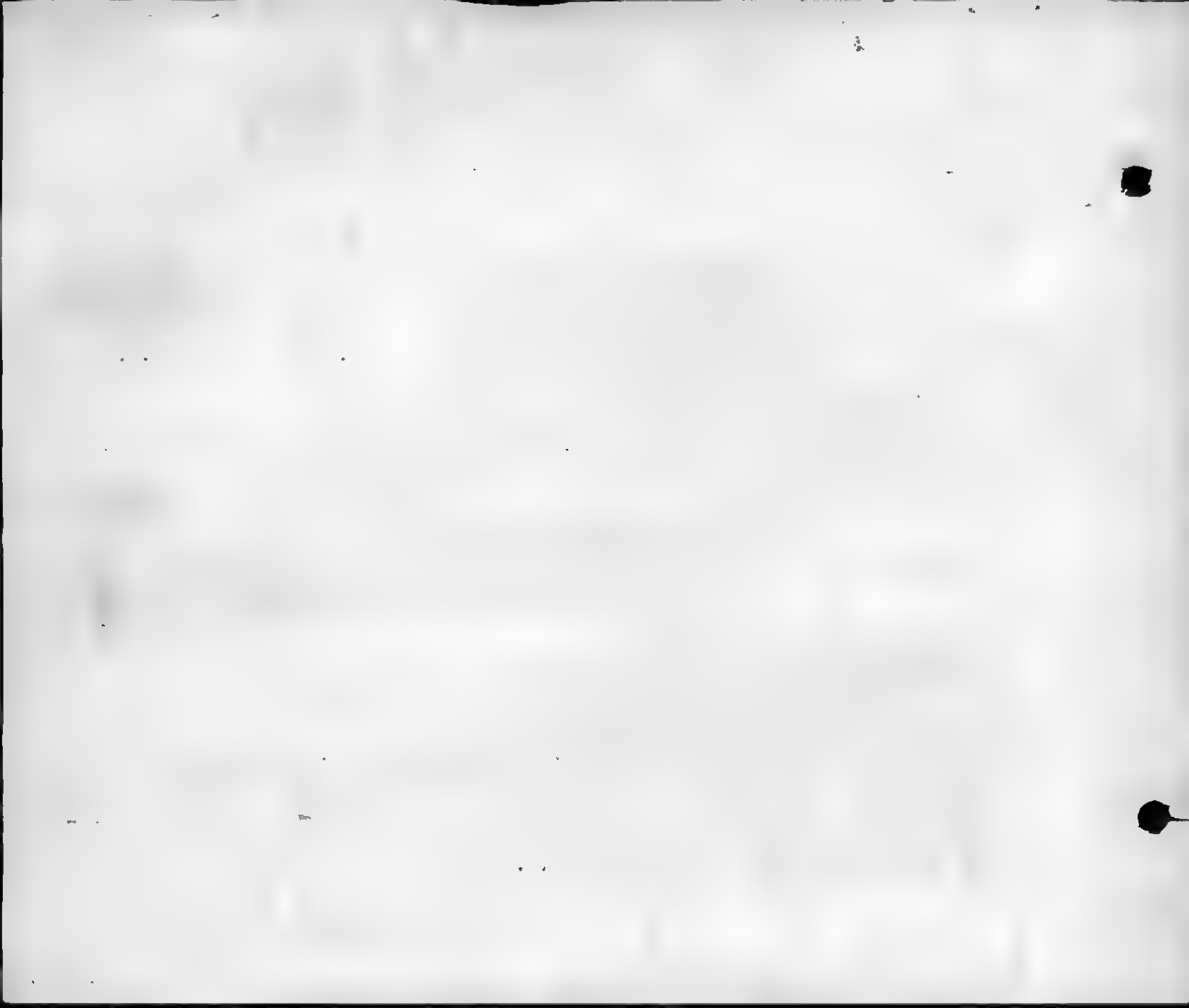
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on- Residence before adm ssion) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>2004 EDGEWOOD STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>B</b> Last <b>COPE Jr</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 31 1918</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <b>RADIO OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT MARINE</b>	
11. BIRTHPLACE (State or foreign country) <b>GREENSBORO, NO. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER B COPE</b>		14. MOTHER'S MAIDEN NAME <b>HELEN TYLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>YES WW-II</b>		16. SOCIAL SECURITY NO. <b>231-05-9531</b>	
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LIVER FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PORTAL CIRRHOSIS</b> DUE TO (c) <b>ALCOHOLISM</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>19 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BILE NEPHROSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29, 1959</b> to <b>AUGUST 1, 1959</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>VAH Fort Howard Maryland</b> DATE SIGNED <b>8-1-59</b>			
ACTUAL SIGNATURE <b>Charles Allen</b> M.D.		PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN</b> M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marion P Armacost</b>		24a. REC'D BY REGISTRAR <b>AUG 3 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>			

6600 Liberty Heights Ave Baltimore Md

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2/57

8795

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08759

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, or institution—Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE MARSH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Neaville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cawenton Ave.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Clifton Christopher Cummings</u>		4. DATE OF DEATH <u>Aug 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Larry Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-12-6485</u>	
17. INFORMANT <u>Sister in Law</u>		Address <u>Cawenton Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adam's Stokes Syndrome</u> (c) <u>arteriosclerosis of age.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u>		DATE SIGNED <u>8/12/59</u>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 14 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Heavitt Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Heavitt Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Harrison</u>		24. REC'D BY REGISTRAR <u>Aug 17 '59</u>	
ADDRESS <u>St Michaels</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

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8796

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6835 Blenheim Rd.</u>		d. STREET ADDRESS <u>6835 Blenheim Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin G. Davis</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin G. Davis, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Emma R. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>213-05-6816</u>	
17. INFORMANT <u>Mrs Hughlo I. Davis</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 min.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Peter J. Dil Van Rens</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '59</u>	
ADDRESS <u>5305 Harford Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Ruck</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8797

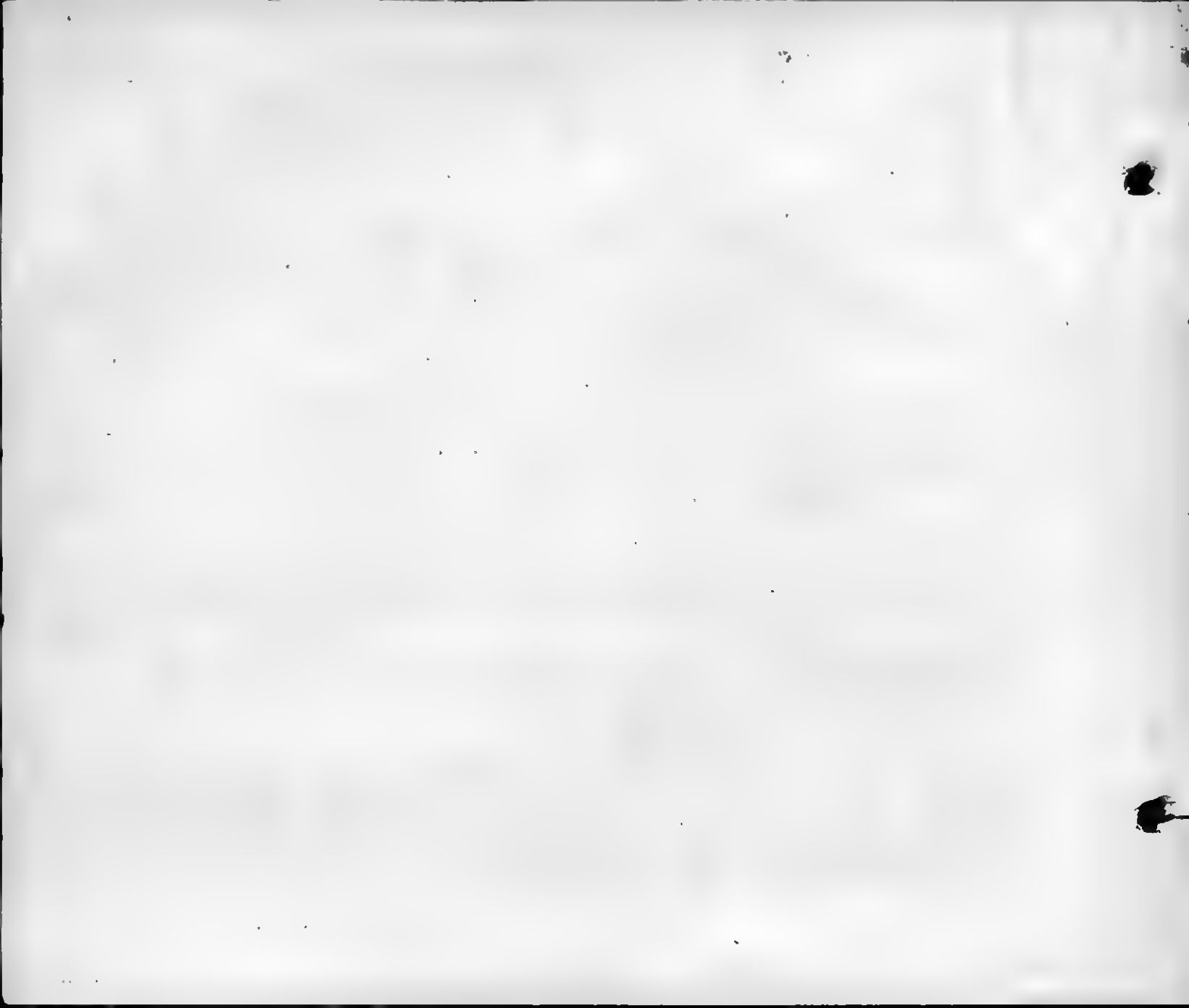
## CERTIFICATE OF DEATH

Reg. Dist. No.

08761

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9225 BELAIR RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>DAVIS</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-29-1876</b>	9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN YOUNG</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET VANSANT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. S. W. BAUMILLER 9225 BELAIR RD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Artery Thrombosis</b> <b>422.1</b> DUE TO <b>Cerebral Artery Other sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized Advanced Atherosclerotic Cardiovascular Disease (under)</b> (b) <b>Generalized Advanced Atherosclerotic Cardiovascular Disease (under)</b> (c) <b>Generalized Advanced Atherosclerotic Cardiovascular Disease (under)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>(under)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug 6</b> , 19 <b>59</b> , to <b>Aug 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 6</b> , 19 <b>59</b> , and that death occurred at <b>3:15 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7520 Belair Rd Balt 6</b> DATE SIGNED <b>F. J. J.</b>							
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. <b>7520 Belair Rd Balt 6 F. J. J.</b>					
PHYSICIAN'S NAME (Type) <b>John C. Hyle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-11-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Funeral Home</b>			ADDRESS <b>7401 Belair Rd</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8763

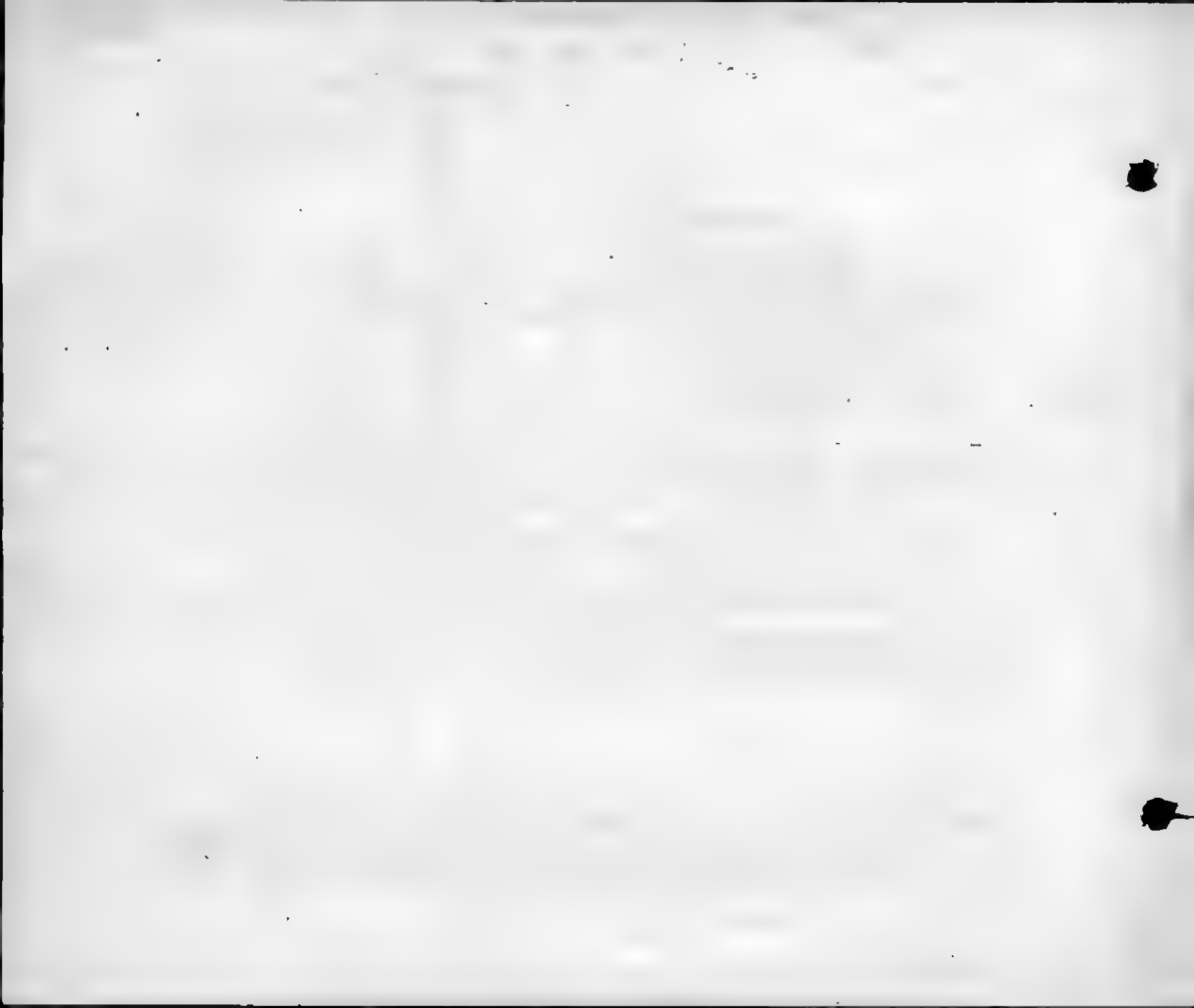
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> 1119 Plover Drive MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>	
c. LENGTH OF STAY IN lb <i>Life</i>		d. STREET ADDRESS <i>5117 Lees Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lillian</i> Middle <i>T.</i> Last <i>Davis</i>		4. DATE OF DEATH Month <i>8</i> Day <i>28</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 17, 1886</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S. A.</i>	
13. FATHER'S NAME <i>Nelson T. Warren</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Tyler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>+</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>-</i>	
17. INFORMANT <i>Ruth Fraley</i>		Address <i>1119 Plover Drive</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory failure</i> 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Malnutrition + Dehydration</i> DUE TO (c) <i>Carcinoma of Bladder</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Metastases.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>58</i> , to <i>28 Aug.</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>28 Aug.</i> , 19 <i>59</i> , and that death occurred at <i>5:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William J. Bryson M.D.</i>		ADDRESS (Street, city or town, state) <i>4605 Edmondson Ave. Balto. Md.</i>	
PHYSICIAN'S NAME (Type) <i>William J. Bryson</i>		DATE SIGNED <i>30 Aug 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/31/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Ambrose Jr.</i>		24a. REC'D BY REGISTRAR <i>1328 Lupton St. Balto.</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>		DATE AUG 31 '59	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8798

Item 3, Film 3-47 3/1/59.cac

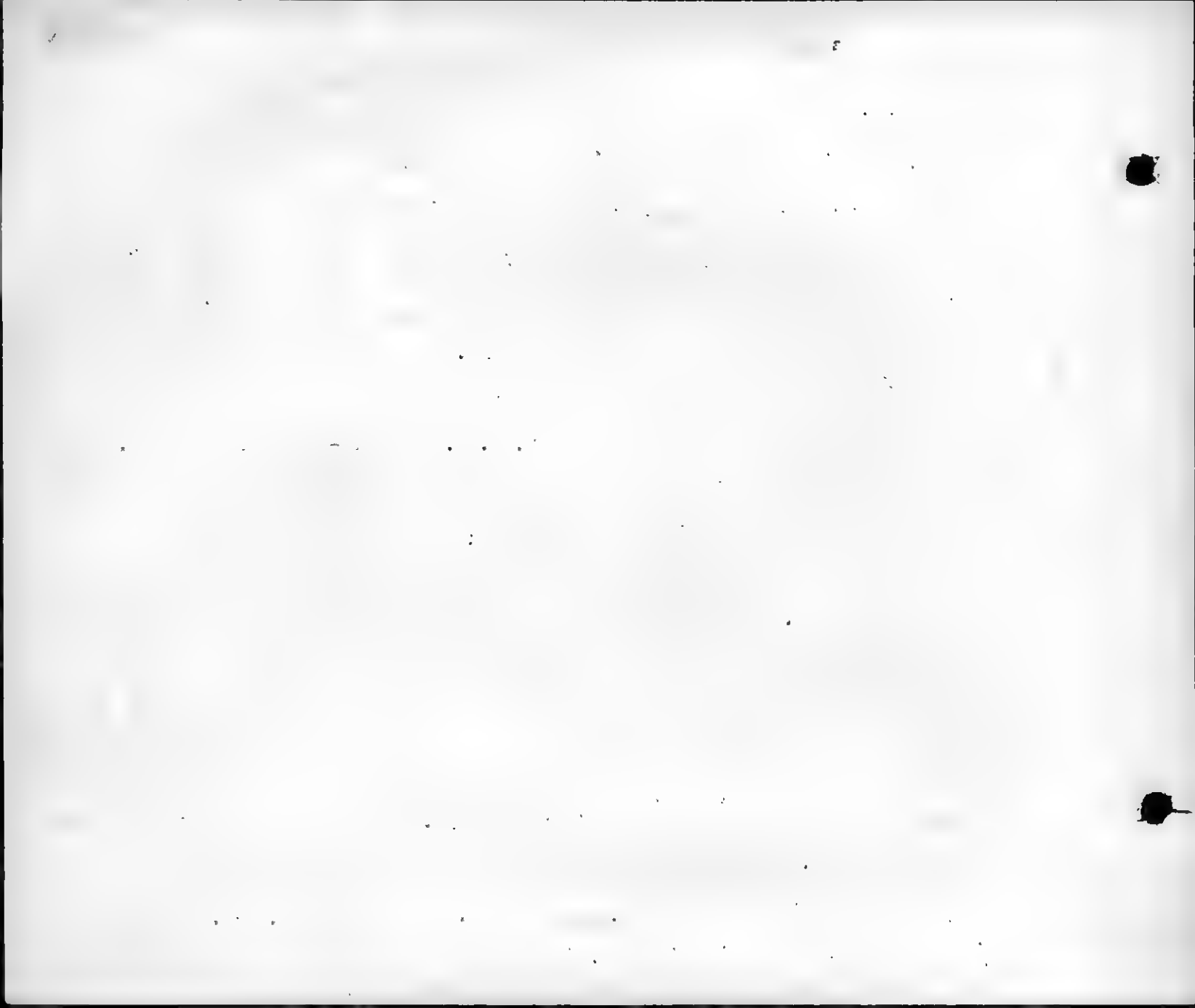
## CERTIFICATE OF DEATH

08763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dwight Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
c. LENGTH OF STAY IN lb <u>16 hours</u>		d. STREET ADDRESS <u>1225 Winston Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Volckert</u> Middle <u>Maximilian</u> de Groot		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/59</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Volckherdt M. de Groot</u>		14. MOTHER'S MAIDEN NAME <u>Mary Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. V. M. deGroot - 1225 Winston Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of stomach content</u> + 2 DUE TO (b) <u>Large inter atrio-ventricular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Defect of heart</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave</u> DATE SIGNED <u>Baltimore 14, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>			
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Lickner</u> ADDRESS <u>4001-17</u>		24a. REGISTRAR'S SIGNATURE <u>Aug 25 '59</u> DATE <u>Aug 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. J. Lickner</u>			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

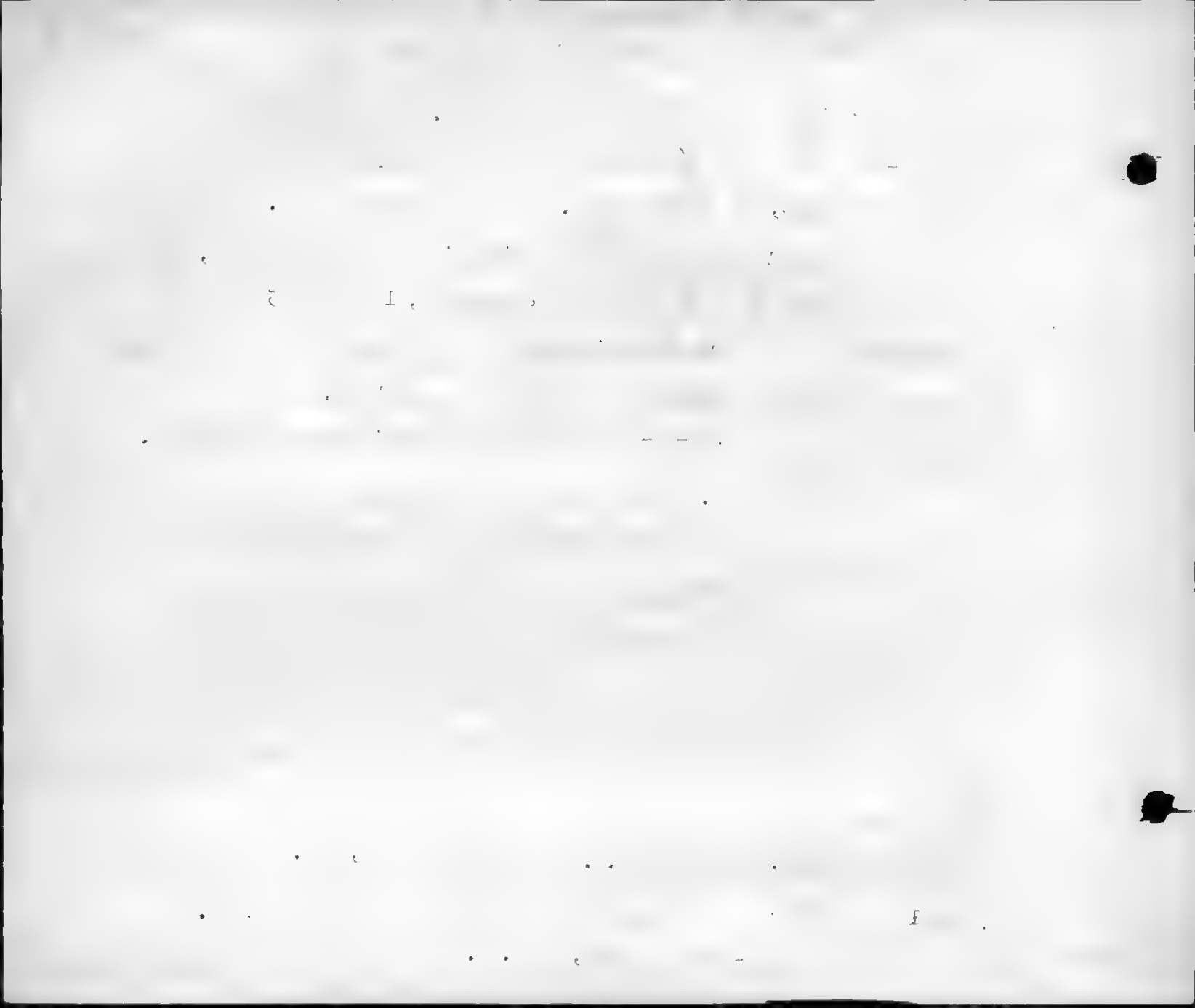
8799

## CERTIFICATE OF DEATH

08764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>16 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home, 98 Smithwood Ave.</b>		d. STREET ADDRESS <b>2817 Waldorf Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>DiBlasi</b> Last <b>DiBlasi</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 20, 1884</b>
9. AGE (In years last birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mens Tailoring Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Salvatore Arena</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-8709</b>	
17. INFORMANT <b>Miss Lee DiBlasi, Marriottsville Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Parkinsons Disease</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>&gt; 1 yr</b> <b>7 1/2 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Diabetes Mellitus (2) A.S.H.D.T Comp Ht Failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-17-1959</b> to <b>8-7-1959</b> , that I last saw the deceased alive on <b>8-1-1959</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 Marston Road, Baltimore 7, Md.</b> DATE SIGNED <b>8/8/59</b>			
ACTUAL SIGNATURE <b>George M. Ramapuram</b>		M.D. <b>George M. Ramapuram, M.D.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Vernon Kemmer</b>		ADDRESS <b>4611 Park Heights, Balto. Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	



8800

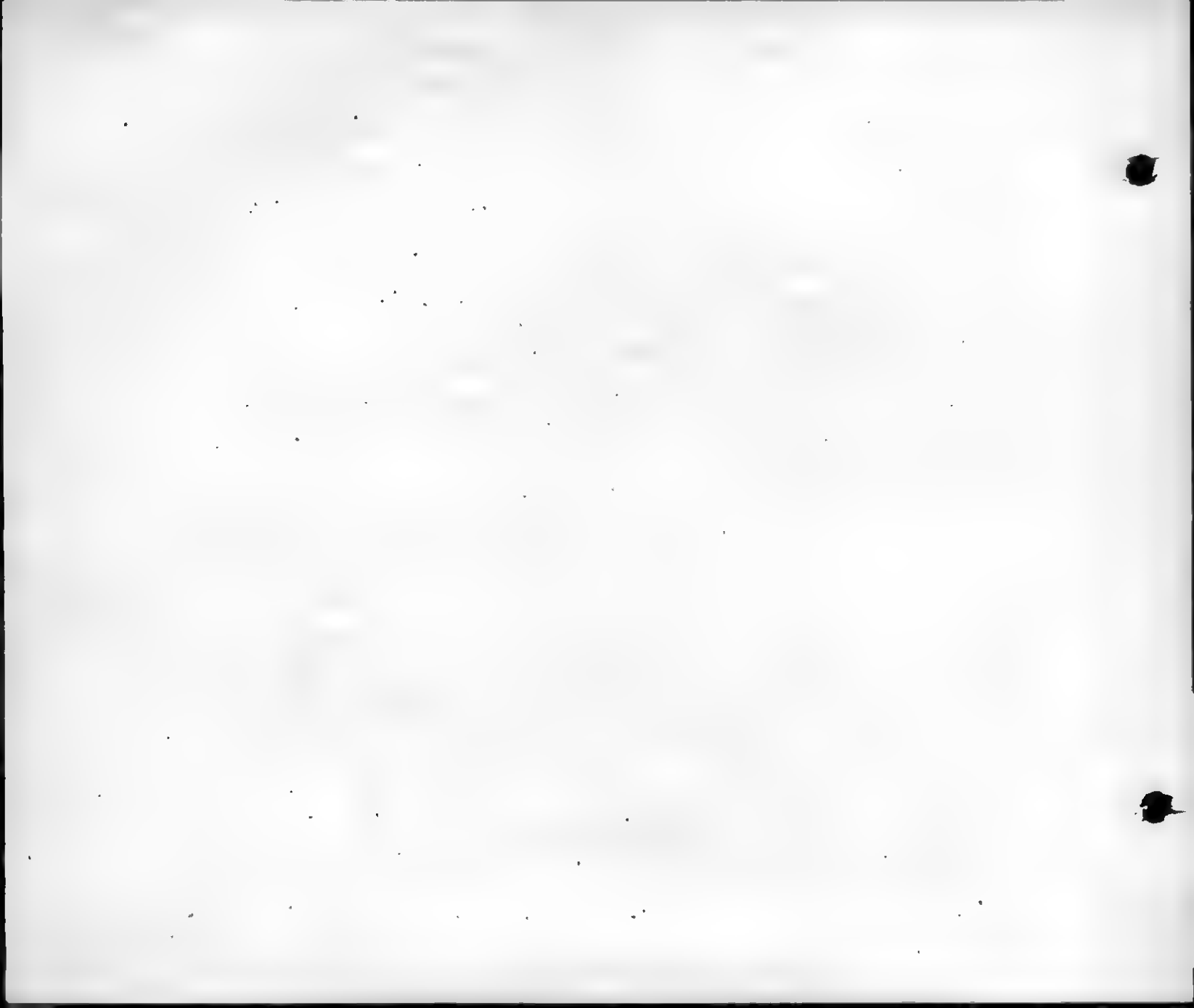
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS HILLS</b> c. LENGTH OF STAY IN 1b <b>53 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> d. STREET ADDRESS <b>312 SMITH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE T DISHARON</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 16 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/1892</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEVER WORK</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>MARCELLUS T. DISHARON</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN HAYMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic and acute pneumonia, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic and acute pneumonia, bilateral</b> (c) <b>Chronic and acute pneumonia, bilateral</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic and acute pneumonia, bilateral</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19</b> , to <b>19</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balt - one 14, Md</b> DATE SIGNED <b>8-17-59</b>			
ACTUAL SIGNATURE <b>Beta W. Rieckert</b>		M.D. <b>4307 14th Ave</b>	
PHYSICIAN'S NAME (Type) <b>Beta W. Rieckert</b>		<b>Balt - one 14, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Md.</b> <b>Norman T. Baker</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 21 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina S. Frank</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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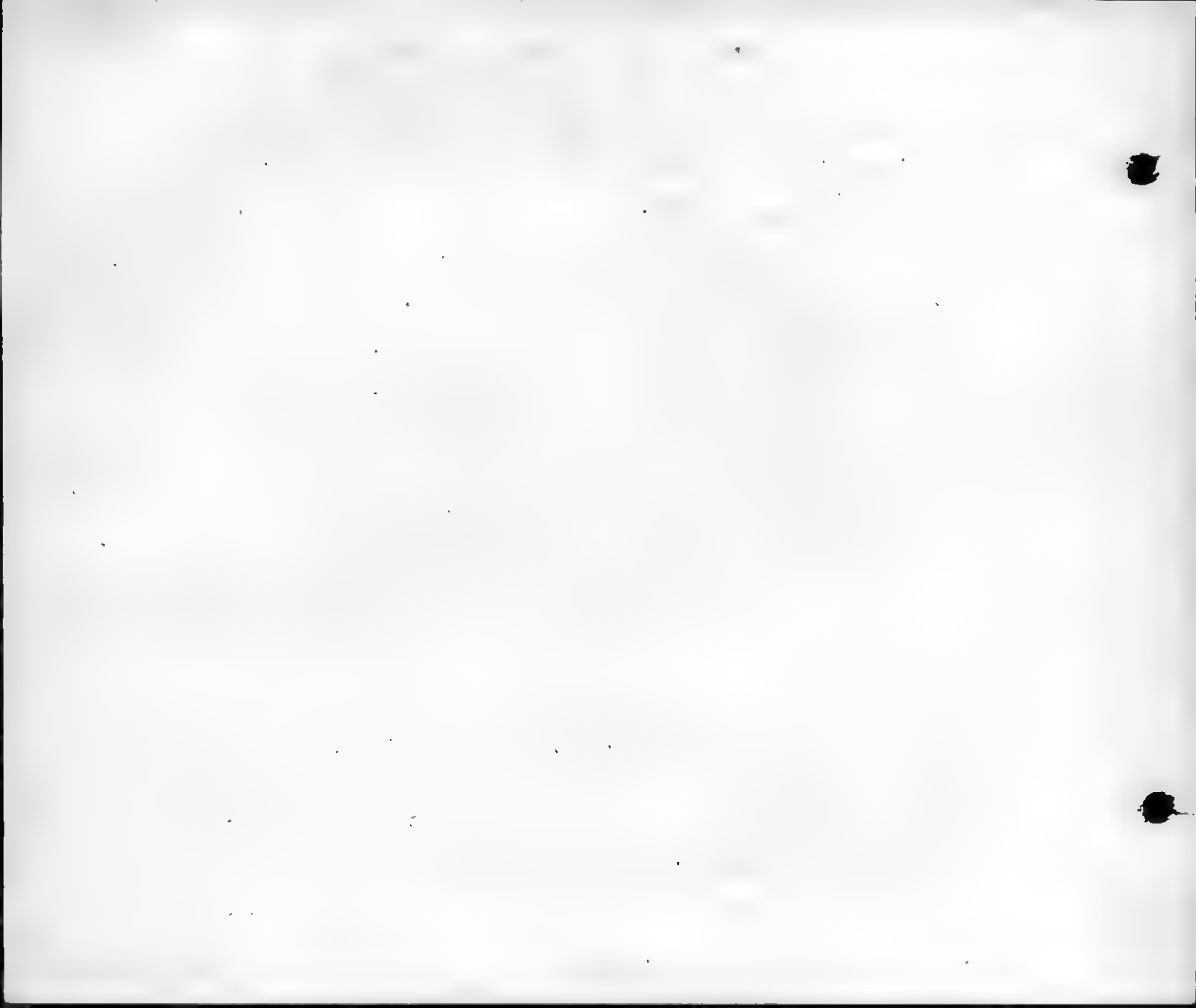
8801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Rusting Ave.</u>		d. STREET ADDRESS <u>3713 41th avenue.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>DONLEY</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Louisanna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Dominick Latapie</u>		14. MOTHER'S MAIDEN NAME <u>Cattie Wagnor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
INFORMANT <u>Raleigh A Donley</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>4-7-1958</u> to <u>8-16-1959</u> , that I last saw the deceased alive on <u>8-15-1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore 28, Md.</u> DATE SIGNED <u>8-17-59</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>		PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '59</u>	
ADDRESS <u>Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Callus &amp; Hume</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: This form requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8802

## CERTIFICATE OF DEATH

Reg. Dist. No.

88767

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9122 Liberty Road</u>		d. STREET ADDRESS <u>9122 Liberty Road</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>F.</u> Last <u>DUNN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1870</u>
9. AGE (In years last birthday) yrs. <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>		13. FATHER'S NAME <u>? Dunn</u>	
14. MOTHER'S MAIDEN NAME <u>? Kirk</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mrs. Ernest E. Greenwalt-9122 Liberty Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASHD. + asthma</u> DUE TO <u></u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>July 30, 1959</u> to <u>Aug 4, 1959</u> , that I last saw the deceased alive on <u>July 30, 1959</u> , and that death occurred at <u>7:41 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8627 Liberty Rd.</u> DATE SIGNED <u></u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>N. J. ELLIN</u> <u>Randallstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u></u>	24a. REC'D BY REGISTRAR <u>5 '59</u>
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8803  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>55 Towson</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>514 Club Lane</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b> d. STREET ADDRESS <b>514 Club Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MINA</b> Middle <b>R.</b> Last <b>DUPRE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 6, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>Alphonse Racin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Andree Moore-514 Club Lane, Towson 4</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis</b> <b>1000.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c) <b>arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 1/2</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 7</b> , 19 <b>59</b> to <b>Aug 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 7</b> , 19 <b>59</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>514 Club Lane, Towson, Md.</b> DATE SIGNED <b>8/11/59</b>							
ACTUAL SIGNATURE <b>Wm Cook-Towson, Inc.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Wm Cook-Towson, Inc.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Aug. 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cote Des Neiges</b>		22d. LOCATION (City, town, or county) (State) <b>Montreal, Canada</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. 1050 York Rd. Towson</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8804 CERTIFICATE OF DEATH

08769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) (Institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth Ensor</b>		4. DATE OF DEATH Month Day Year <b>8-1-59</b> 19	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1874</b>
9. AGE (In years last birthday) yrs <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward A. Sparks</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Sparks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Lawrence E. Ensor, Campbell</b>		Address <b>Towson 4, Md. Bldg.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericarditis</b> <b>4349</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December, 1958</b> , to <b>July, 1959</b> , that I last saw the deceased alive on <b>July 21<sup>st</sup>, 1959</b> , and that death occurred at <b>7 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1927 York Rd, Timonville Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>M. X. Quinn</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-3-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>	22d. LOCATION (City, town or county) (State) <b>Cockeysville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paradise Nursing Home</i>		d. STREET ADDRESS <i>46 Carroll Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>ERNEST</i> Last		4. DATE OF DEATH Month <i>Aug</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 1 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Maximilian Polzner</i>		14. MOTHER'S MAIDEN NAME <i>Marcia Bidojska</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>family. Jane</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i> <i>171X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>carcinoma of cervix advanced. Prior</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May</i> 19 <i>59</i> , to <i>Aug 16</i> 19 <i>59</i> , that I last saw the deceased alive on <i>Aug 14</i> 19 <i>59</i> , and that death occurred at <i>4 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Frederick M. Zerkavsky</i> M.D.		PHYSICIAN'S NAME (Type) <i>FREDERICK M. ZERKAVSKY 1202 St. Paul West Baltimore 2nd</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>8-20-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McClary Funeral Home</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>AUG 18 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form D-13. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8806 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G248 9-17-59 et

Reg. Dist. No. 08771

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradford</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 7 and Raffel Road</b>		d. STREET ADDRESS <b>Spring and Pratt Sts.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle Last <b>EVANS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>49</b> yrs.
9. AGE (In years last birthday) <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Arundel N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arnell Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Slout</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles S. Petty</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>1220.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		DATE SIGNED <b>8/22/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>mt Calvary Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Brooklyn Md D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Petty</b>		ADDRESS <b>1000</b>	
24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kona</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8807

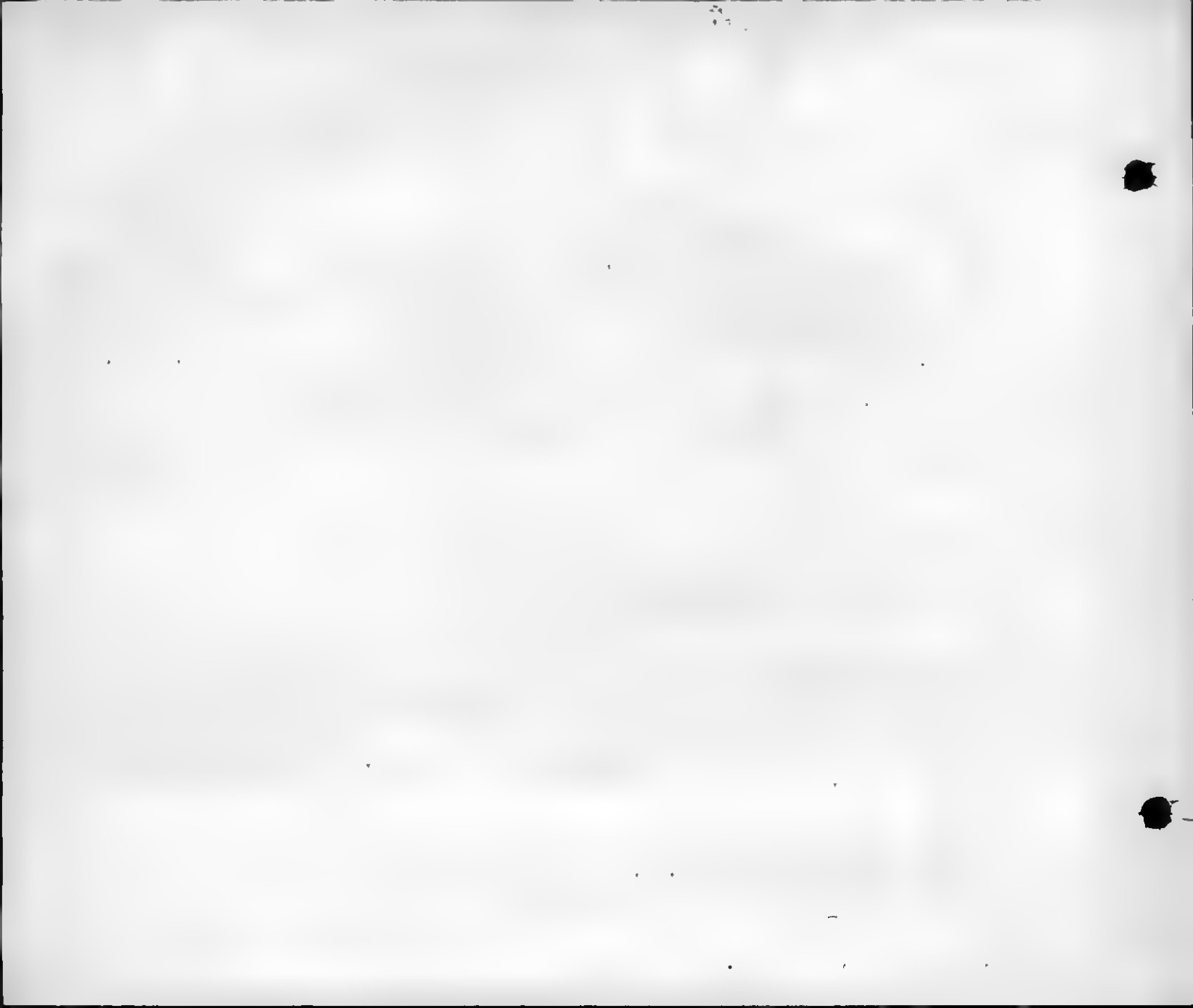
## CERTIFICATE OF DEATH

08772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>26yr9mth19dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>G.</u> Last <u>Favour</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph G. Favour</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Standiford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Aug. 13, 19 59</u> to <u>Aug. 18, 19 59</u> , that I last saw the deceased alive on <u>Aug. 18, 19 59</u> , and that death occurred at <u>9:30a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 8-18-59</u>			
ACTUAL SIGNATURE <u>Stella Wachsler</u> M D		PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u> <u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8808

## CERTIFICATE OF DEATH

08773

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>18 LOCUST DRIVE</b>		d. STREET ADDRESS <b>18 LOCUST DRIVE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>ANASTASIA H. FIELDS</b>		4. DATE OF DEATH Month Day Year <b>AUG. 20 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 19, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>DAVID HAGGERTY</b>	
14. MOTHER'S MAIDEN NAME <b>JOHANNA O'KEEFE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>MISS VIRGINIA FIELDS-18 LOCUST DRIVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Degenerative C.V. Disease</b> DUE TO <b>Generalized Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1956</b> to <b>Aug 20, 1959</b> that I last saw the deceased alive on <b>Aug 20, 1959</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jacques B. Howell</b>		ADDRESS (Street, city or town, state) <b>Catonville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Jacques B. Howell</b>		DATE SIGNED <b>8-22</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-24-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home - Catonsville, Md.</b>		ADDRESS <b>Catonville, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8809

## CERTIFICATE OF DEATH

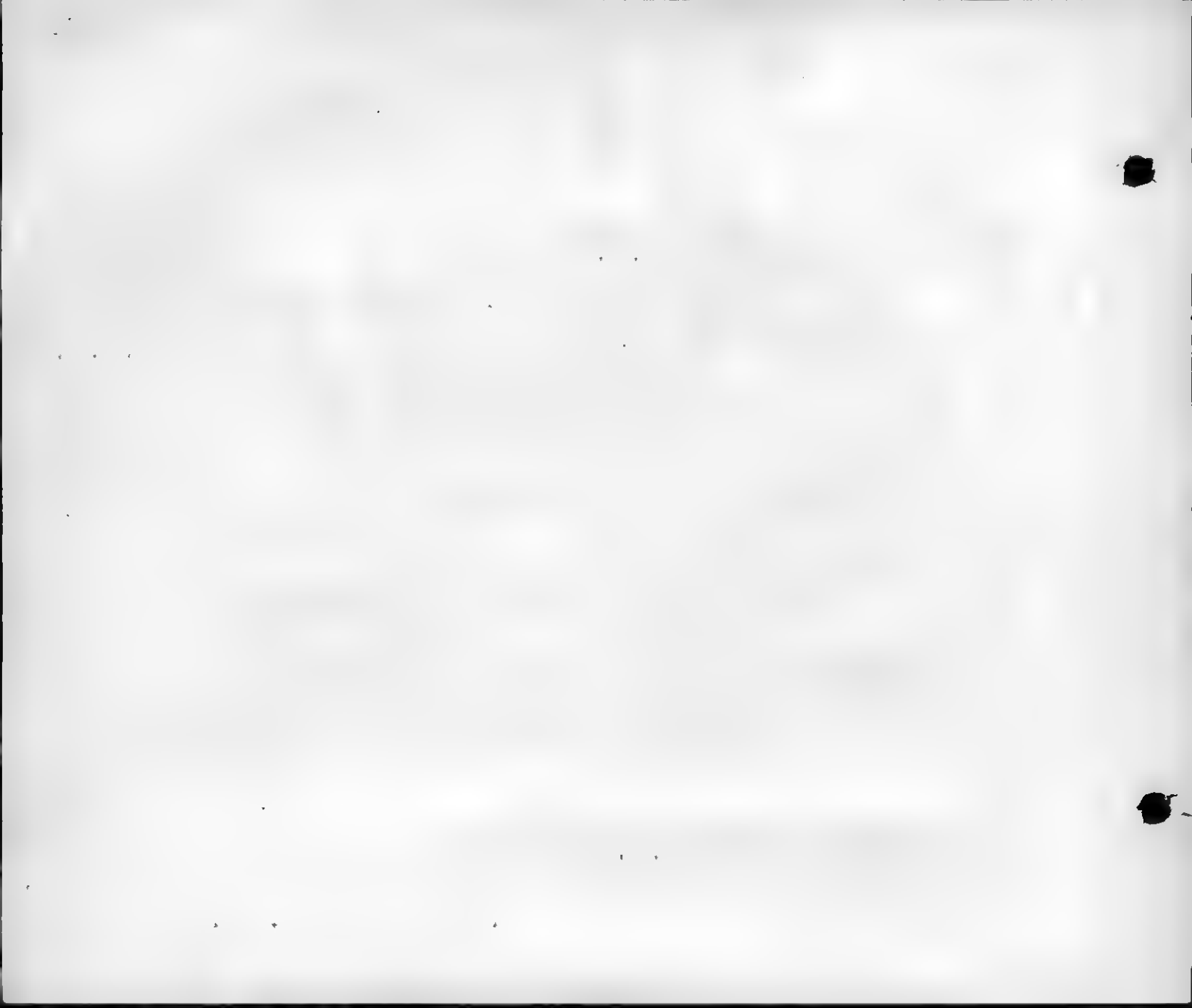
Reg. Dist. No.

08774

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V 1.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3905 Wilkens Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fredrick</b> Middle <b>E. W.</b> Last <b>Foos</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>candymaker (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectioner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <del>Unknown</del> <b>William Foos</b>		14. MOTHER'S MAIDEN NAME <del>Unknown</del> <b>Mary Heinz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <del>Unknown</del> <b>none</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 wks</b> <b>Undetermined</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 30, 1959</b> to <b>August 31, 1959</b> , that I last saw the deceased alive on <b>August 30, 1959</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Edward T. Schnoor, M.D.</b>		ADDRESS (Street, city or town, state) <b>3718 Belvedere Rd. Baltimore 16, Md.</b>	
DATE SIGNED <b>8-31-59</b>			
PHYSICIAN'S NAME (Type) <b>Edward T. Schnoor, M.D.</b>		<b>SPRING GROVE STATE HOSPITAL - Catonsville</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Am. J. Lieber &amp; Sons - Baltore</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Waring &amp; Howard</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

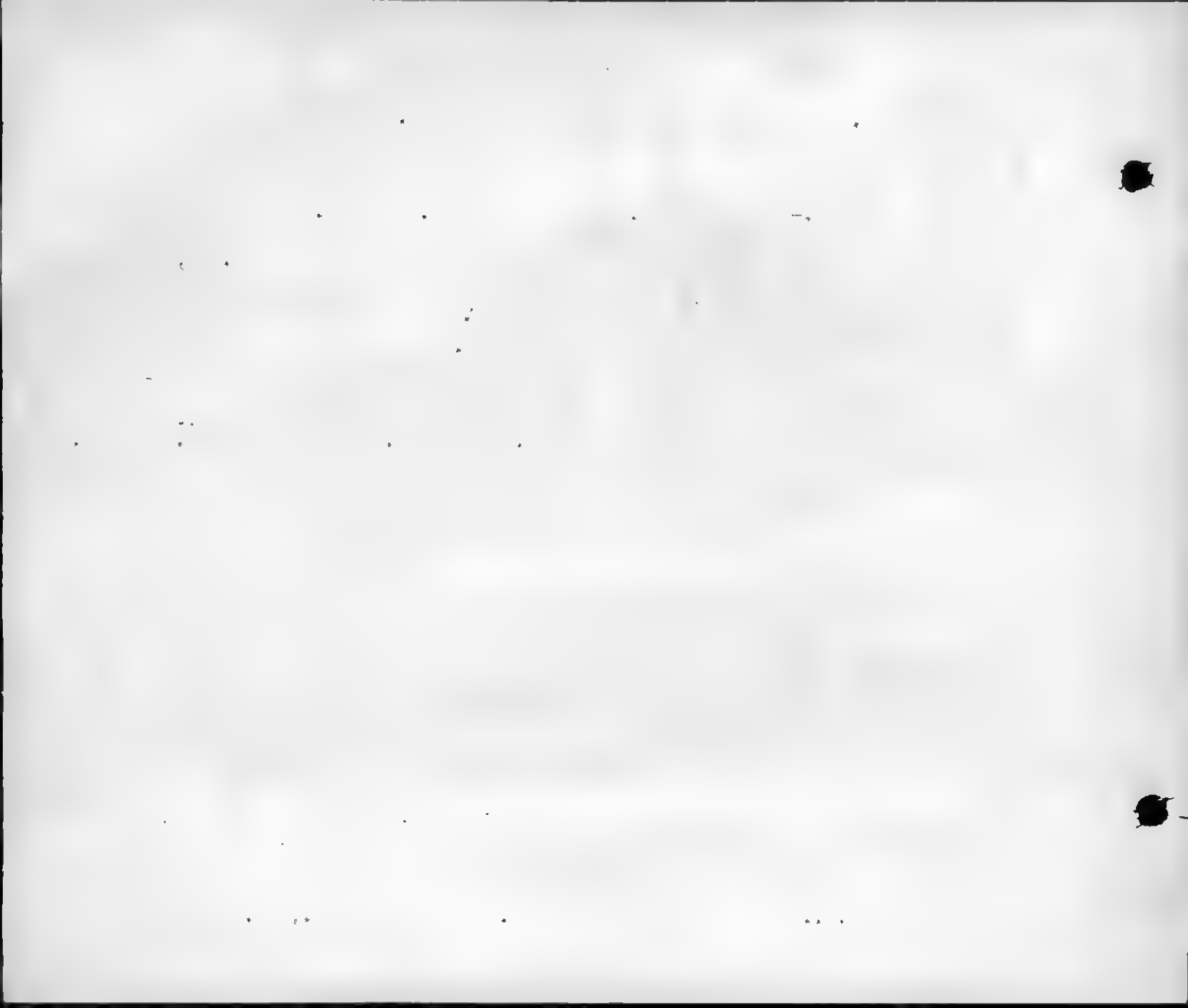
08775

8810

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fried Nursing Ho., -133 Slade Ave.</b>		d. STREET ADDRESS <b>308 E. 26th St.</b>	
3 NAME OF DECEASED (Type or print) First <b>PHOEBE</b> Middle <b>FRANKLIN</b> Last		4. DATE OF DEATH Month <b>Aug.</b> Day <b>21,</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1883</b>
9 AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Willard Green</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Miss Dorothy L. Franklin - 308 E. 26th St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1959</b> , to <b>Aug 21, 1959</b> , that I last saw the deceased alive on <b>Aug 21, 1959</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry G. Lassman</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>712 W. Fayette St.</b>	
PHYSICIAN'S NAME (Type) <b>HARRY G. LASSMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8.24.59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickerson &amp; Sons - Balt., Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



FOR STATE  
HEALTH DEPT.

8811

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6240 9-8-59 et

08776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>B. It.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2226 Powers Lane</u>		e. d. STREET ADDRESS <u>2226 Powers Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Rose Ann Frederick</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896 Dec. 3, 1897</u>
9. AGE (In years last b. day) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>-- Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Antkowiak</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Frederick 2226 Powers Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>GEO. S. M. KPEFFER MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KPEFFER MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8812

CERTIFICATE OF DEATH

Reg. Dist. No.

08777

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - WOODLAWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - WOODLAWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6608 TALLULAH AVE</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GALLMEYER CHARLES</b> Middle <b>ALBERT</b>		4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WIFE MRS GRACE GALLMEYER</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> <b>PROBABLE ORIGIN - STOMACH.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 12, 1952</b> to <b>AUGUST 13, 1959</b> , that I last saw the deceased alive on <b>AUGUST 11, 1959</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD, BALTO, MD</b> DATE SIGNED <b>8/13/59</b> ACTUAL SIGNATURE <b>Edwin L. Pierpont</b> PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>AAco. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>	
ADDRESS <b>6411 Windsor Mill Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hunk</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

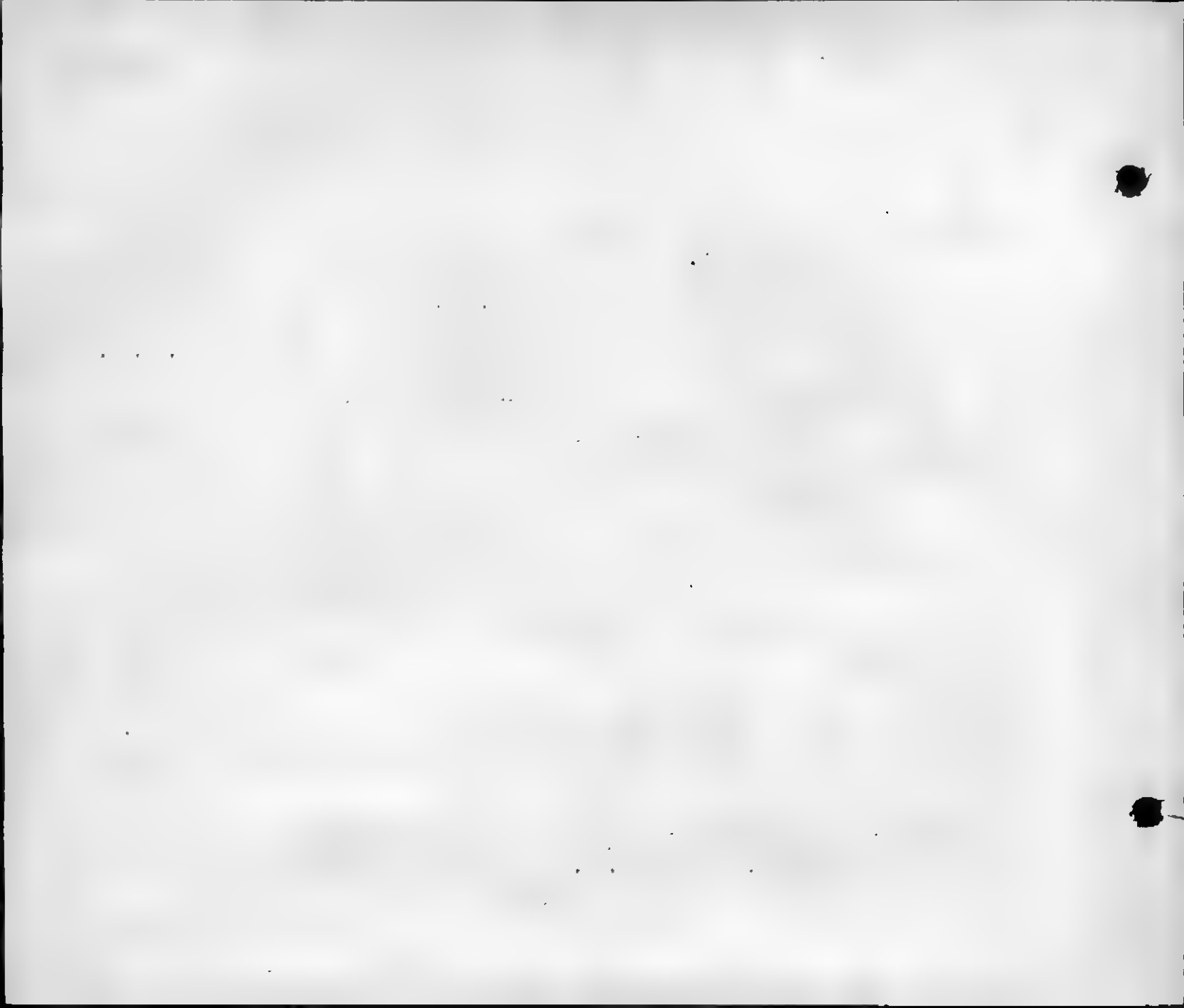
8813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 08778

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth18days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>4008 Penhrust Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Caroline <del>Gardner</del> T. <del>Thomas</del> Gardner</b>		4. DATE OF DEATH <b>August 1 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Augustus Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Anm Rebecca Airhardt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of serv co) <b>unknown No</b>		16. SOCIAL SECURITY NO. <b>XXXXXXXXXX No</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia due to</b> <b>904.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Cardiovascular disease</b> (c) <b>Intertumescence Fracture Rt. Femur</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>possible fall accident</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <b>No history of fall found in the milt injured hip</b> 20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>July 17 1959</b> p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b> 20f. (City or town) (County) (State) <b>Catonsville 28, Md.</b> 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Aug 59</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur9ap</b> 22b. DATE-THEREOF <b>8/3/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. ...</b> ADDRESS <b>17714</b> 24a. REC'D BY REGISTRAR <b>DATE AUG 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>...</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**08779**

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN TB <b>?</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence, 211 Cleveland Ave.</b>		e. STREET ADDRESS <b>211 Cleveland Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Steve</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1892</b>
9. AGE (in years and month) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>193-07-7213</b>	
17. INFORMANT <b>Mrs. Teresa Gaydos</b>		Address <b>211 Cleveland Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>A-S-C-U DISEASE</b> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m <b>0</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>None</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 13, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>	
ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Tharr</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

8814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>4214 Highland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mignon G. Senora</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
First Middle Last		4. DATE OF DEATH <u>Aug 1, 1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1916</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Goldie Kann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>no</u>		16. SOCIAL SECURITY NO <u>216-01-3549</u>	
17. INFORMANT <u>David Senora</u> Address <u>4214 Highland Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of the breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 year</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1</u> to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/1</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Burgin</u>		ADDRESS (Street, city or town, state) <u>6721 Leisterwood Rd. Balto. 15, Md.</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD BURGIN</u>		DATE SIGNED <u>8/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Leunen &amp; Bros</u>		ADDRESS <u>1124-26 N. North Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

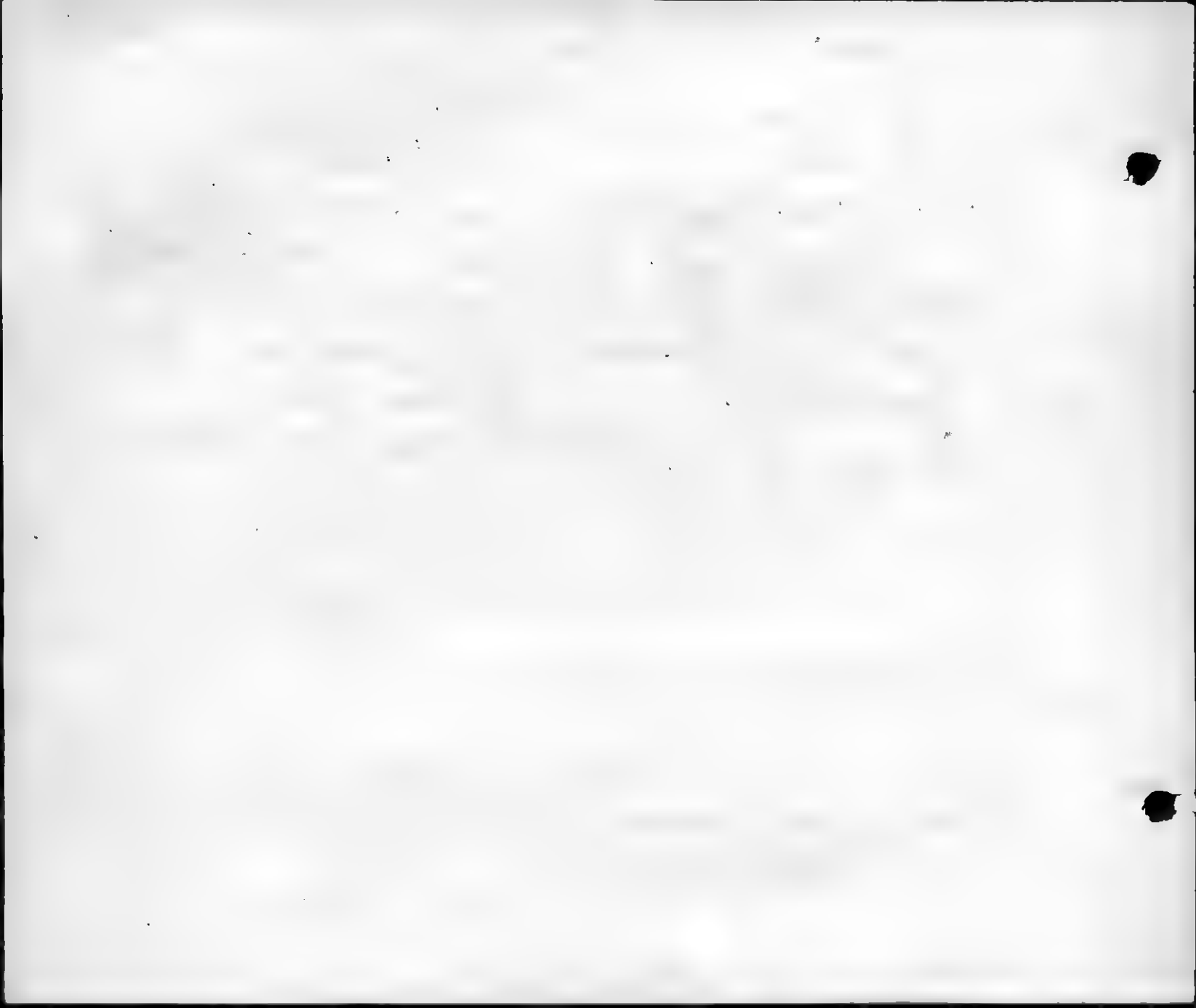
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

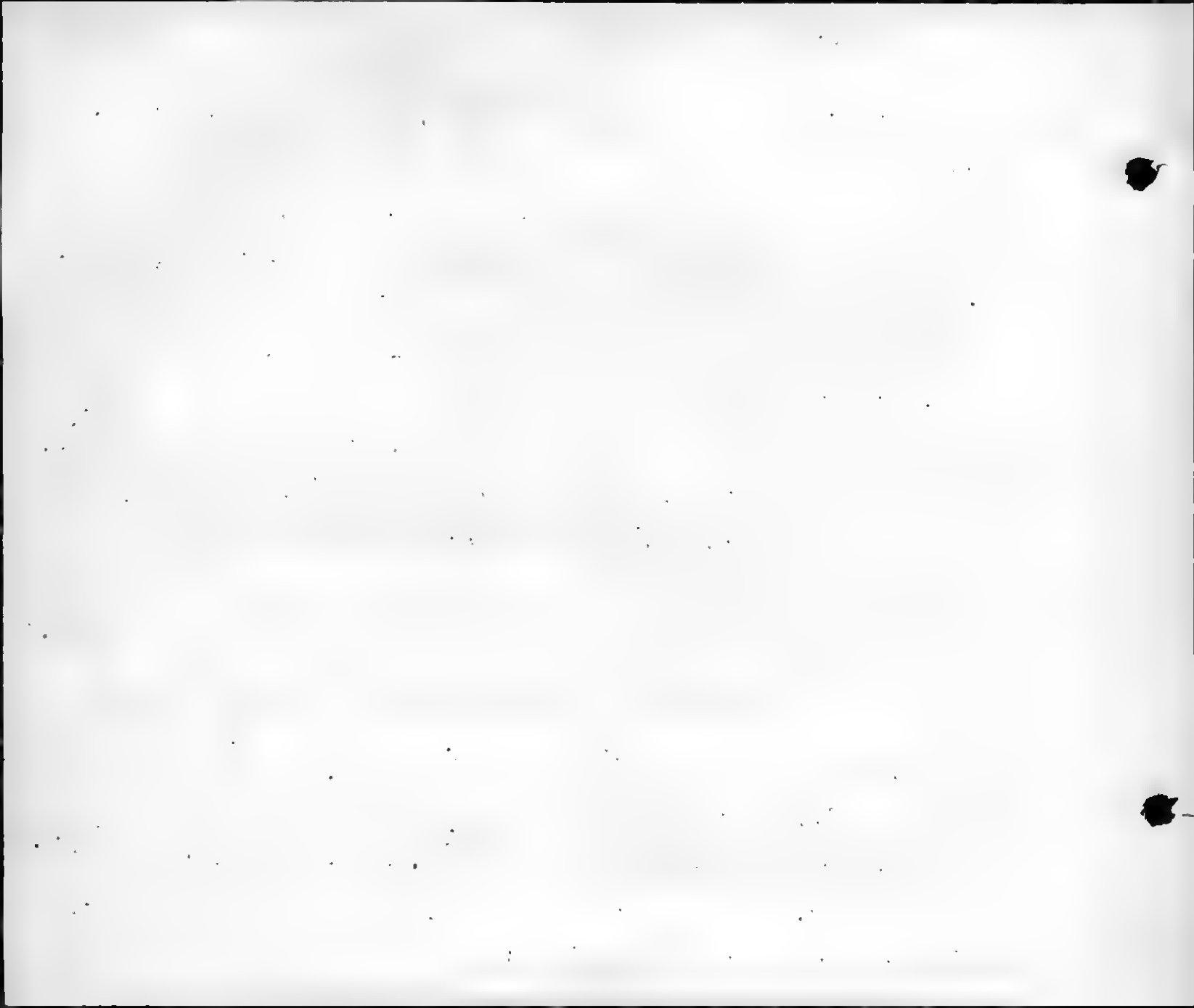
VS A15 (4)  
ISM 9/58

1  
Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8815 Item 1 Film G247 8-27-59 et  
CERTIFICATE OF DEATH

08781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 100 Clarendon Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy Lillian Goode</u>		4. DATE OF DEATH Month Day Year <u>August 16, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1885</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houswife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Author Brown</u>		14. MOTHER'S MAIDEN NAME <u>Crawford C Richmond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>INFORMANT</u>	
17. ADDRESS <u>Pikesville 8, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident, rt hemi-</u> <u>44-18</u> DUE TO <u>parietal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>10 years</u> (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> to <u>16 Aug.</u> , 19 <u>59</u> that I last saw the deceased alive on <u>14 Aug.</u> , 19 <u>59</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H Royse</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>808 Reisterstown Rd. 16 Aug. '59</u>	
PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Pikesville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 21 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8815

CERTIFICATE OF DEATH

19930

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 7		c. LENGTH OF STAY IN <u>8 month</u> (Rural) x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home, 4105 Essex Rd.</u>		d. STREET ADDRESS <u>Winans Road</u>	
3 NAME OF DECEASED (Type or print) <u>Douglas</u> First Middle Last <u>Gray</u>		4. DATE OF DEATH <u>Aug</u> Month <u>17</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Gray</u>		14 MOTHER'S MAIDEN NAME <u>May Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Katherine Robb</u> Address <u>4105 Essex Rd., #7, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7230 Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7230</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, hypertrophic</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>14 Sept</u> , 19 <u>50</u> , to <u>8-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-17</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles V. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1632 Reisters town Rd.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery, Pikesville 8, Md.</u>	
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell, Pikesville 8, Md.</u> ADDRESS		24. REC'D BY REGISTRAR <u>SEP 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

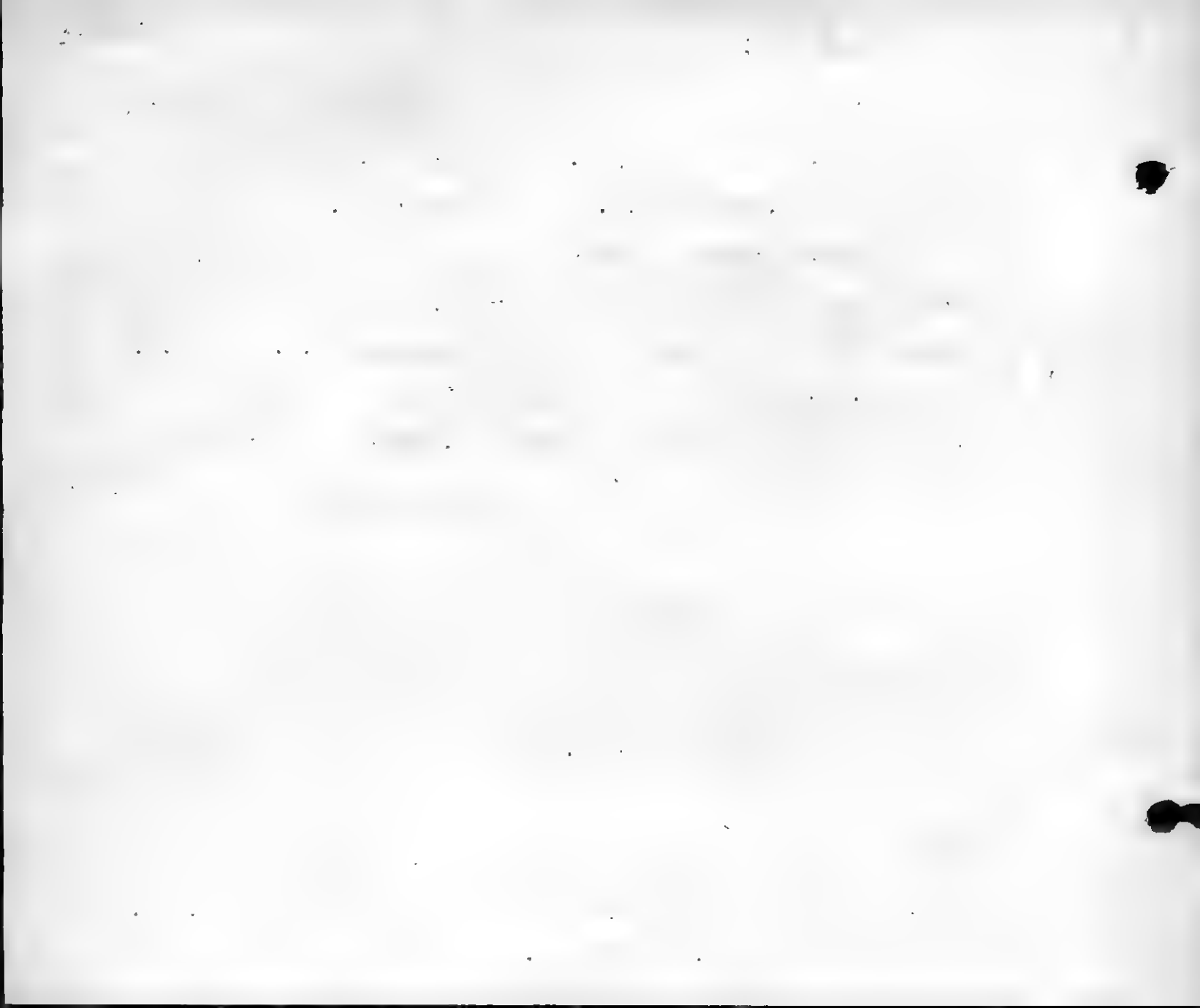


8818

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12,</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa, Bellona Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Bartley</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>8-7-59</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1879</b>
9. AGE (In years last birthday) <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James W. Bartley</b>	
14. MOTHER'S MAIDEN NAME <b>Gigone</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Laurie M. Green</b> Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>Arteriosclerotic Cardio-Vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 1<sup>st</sup>, 1957</b> , to <b>August 7<sup>th</sup>, 1959</b> , that I last saw the deceased alive on <b>August 7<sup>th</sup>, 1959</b> , and that death occurred at <b>1:30 p.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip D. Flynn</b>		ADDRESS (Street, city or town, state) <b>Baltimore 6, Md.</b> DATE SIGNED <b>August 9<sup>th</sup>, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Philip D. Flynn</b>		DATE SIGNED <b>August 9<sup>th</sup>, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 6, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

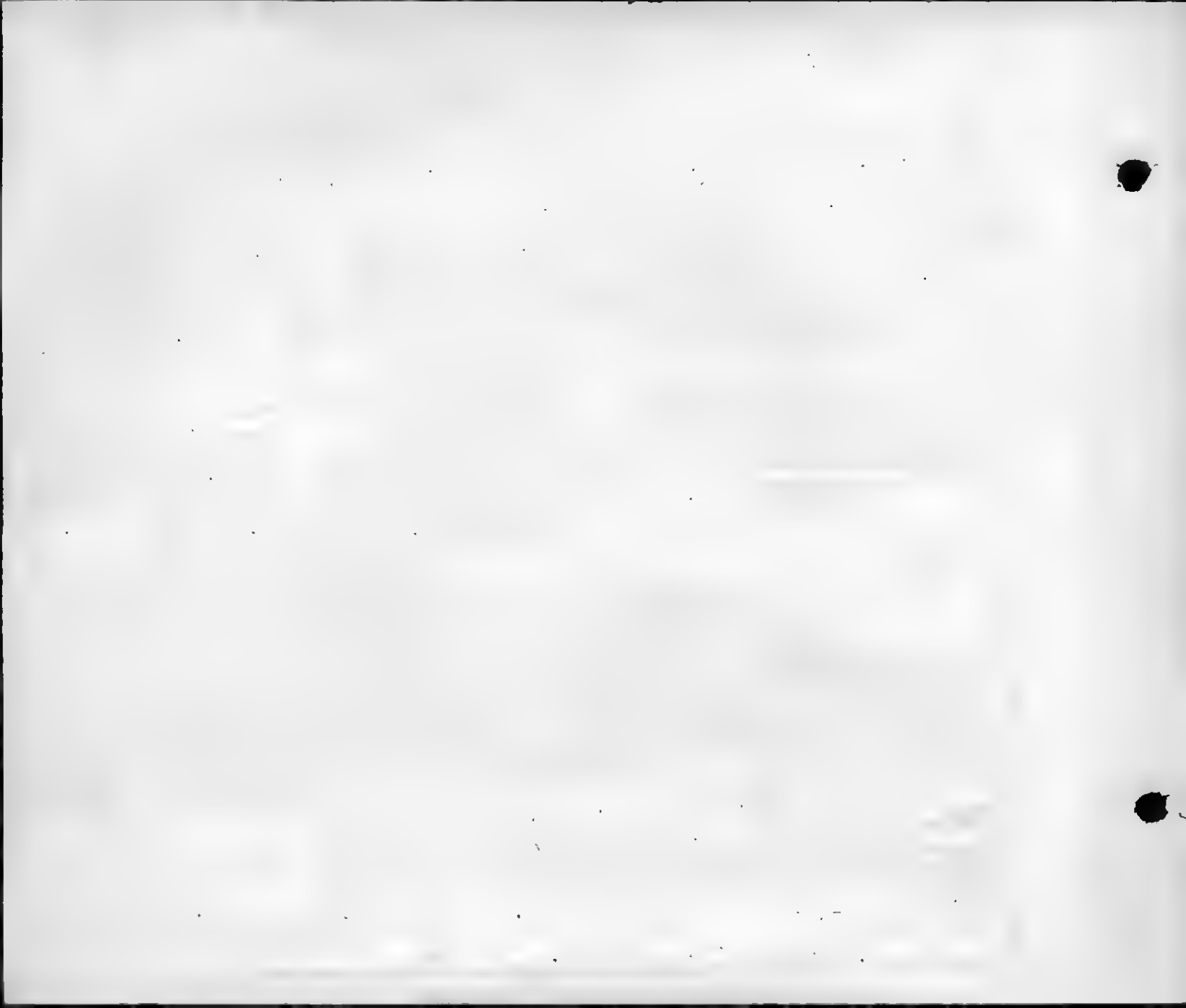
8817

08782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>7811 Oakleigh</u>		d. STREET ADDRESS <u>7811 Oakleigh</u>	
3. NAME OF DECEASED (Type or print) <u>Simon</u> First <u>Gregory</u> Middle <u>G</u> Last <u>G</u>		4. DATE OF DEATH <u>Aug 24</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>66</u> yrs <u>66</u> Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russian</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wife, Same</u> Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X</u> DUE TO <u>Anemia and hepatic degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Generalized Carcinomatous Adenocarc. Stomach</u> (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED <u>—</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>June</u> 19 <u>58</u> to <u>Aug</u> 19 <u>59</u> that I last saw the deceased alive on <u>Aug 24</u> 19 <u>59</u> and that death occurred at <u>7:40</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T Kasik</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Hartford Rd Balto 14 Md</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>		DATE SIGNED <u>9/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hartford Rd.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8764

## CERTIFICATE OF DEATH

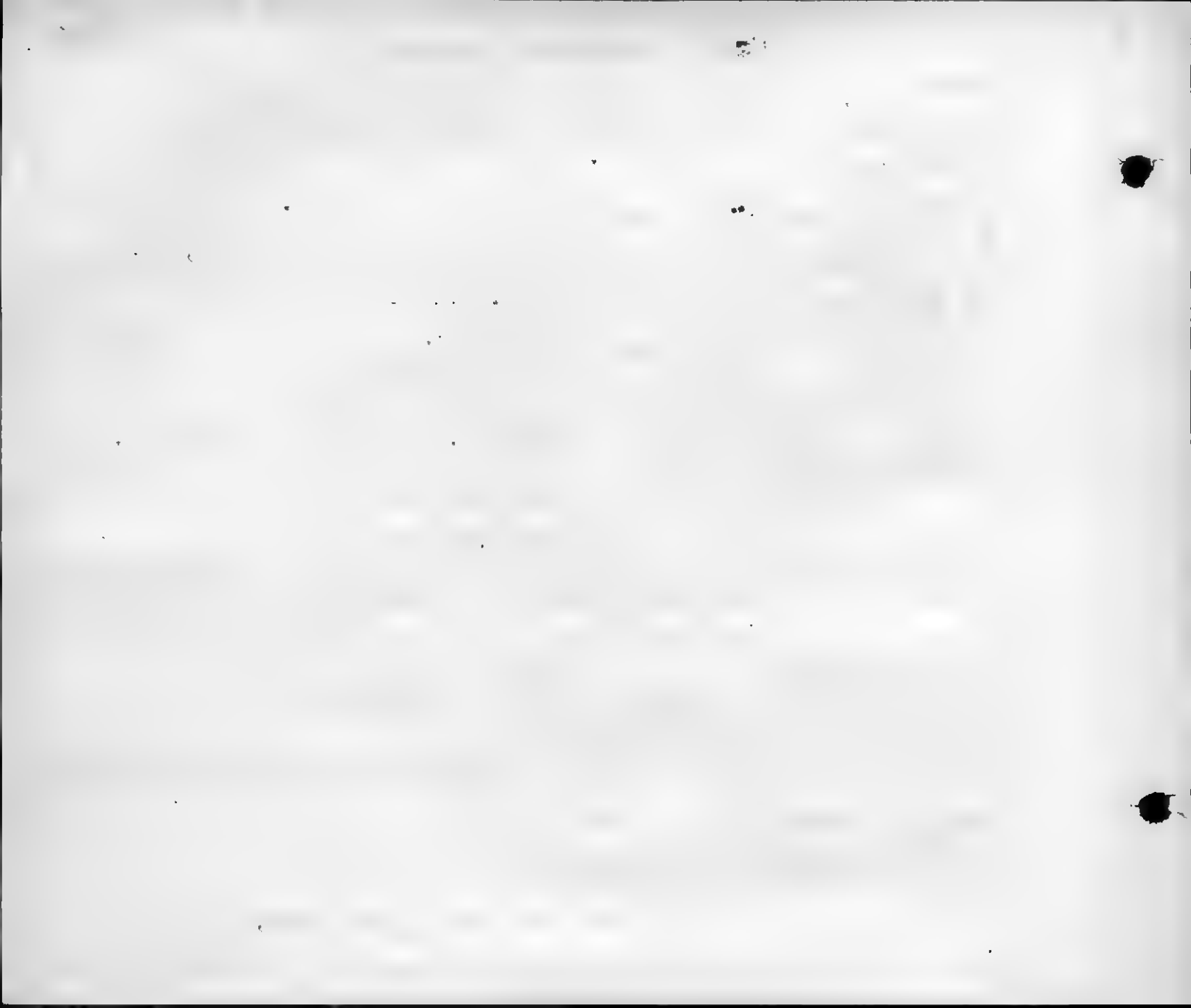
08784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>23 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1325 Stevens Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Grikrit</b>		4. DATE OF DEATH <b>August 13, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Latavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Latavia</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Seodon A. Grikrit</b>		Address <b>1325 Stevens Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO (c) <b>20 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 6, 1959</b> to <b>Aug 13, 1959</b> , that I last saw the deceased alive on <b>Aug 13, 1959</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Donald R. Lewis</b> M.D.		DATE SIGNED <b>St. Agnes Hospital 8/14/59</b>	
22. NAME OF DECEASED (Type) <b>Mary Grikrit</b>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>		24a. REC'D BY REGISTRAR <b>AUG 17 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton S. Lewis</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8819

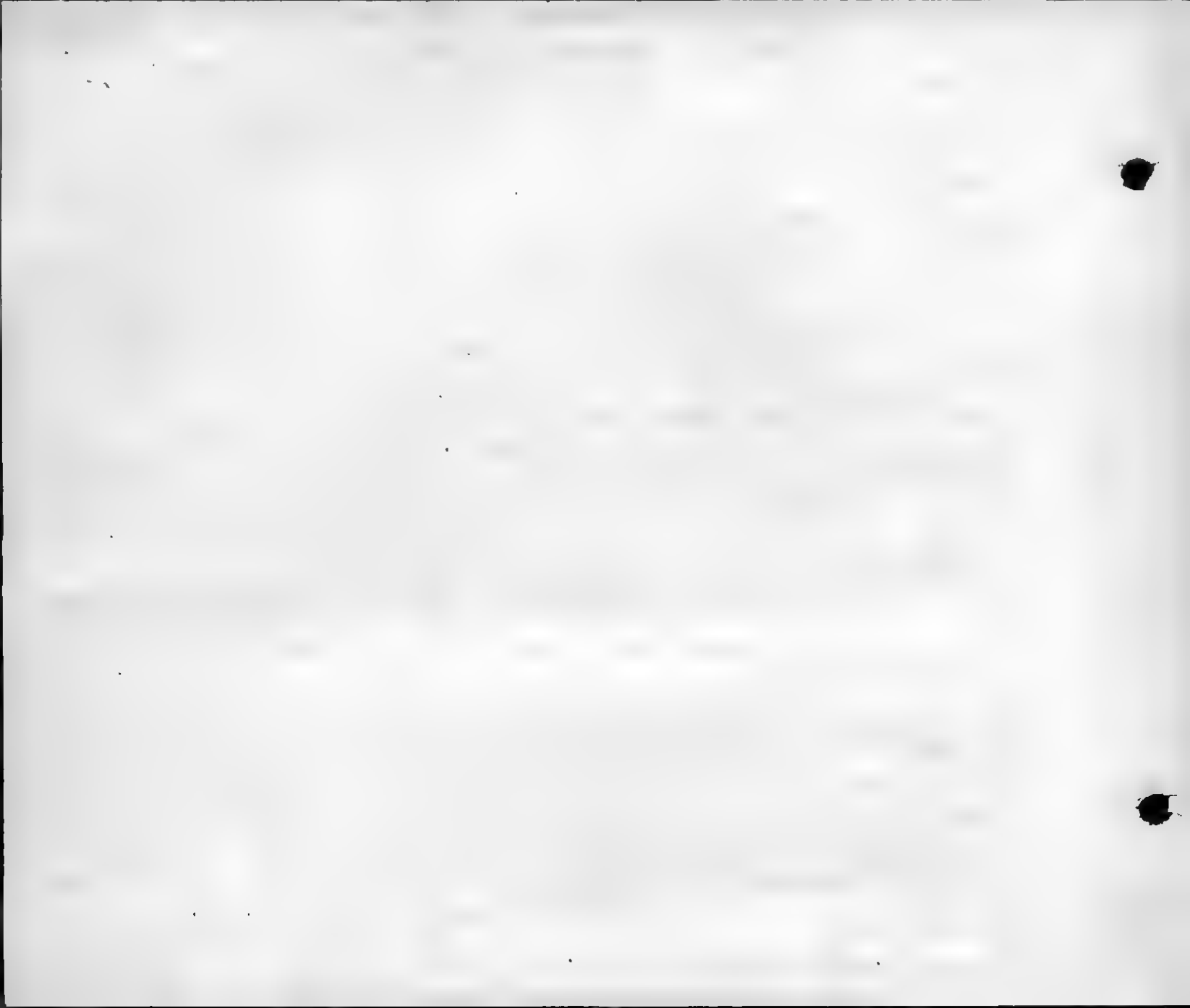
## CERTIFICATE OF DEATH

08785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>214 Leslie</b>		d. STREET ADDRESS <b>1214 Leslie</b>	
3. NAME OF DECEASED (Type or print) <b>EVA First M. GUNTHER Last</b>		4. DATE OF DEATH <b>Aug 10 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 1895</b>
9. AGE (In years, months, days, hours, minutes) <b>63 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Baier</b>		14. MOTHER'S MAIDEN NAME <b>Laura Rose Walsrum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James J. Gunther</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4. Congestive Heart Failure</b> DUE TO <b>Myocardial degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Atherosclerosis!</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>13 yr +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1957</b> to <b>Aug 1959</b> that I last saw the deceased alive on <b>June 1959</b> and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>9005 Harford Rd BALTO 14 MD</b>	
ACTUAL SIGNATURE <b>Frank J. Ruck</b>		DATE SIGNED <b>8/10/59</b>	
PHYSICIAN'S NAME (Type) <b>FT. KASIK JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-13-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8820

## CERTIFICATE OF DEATH

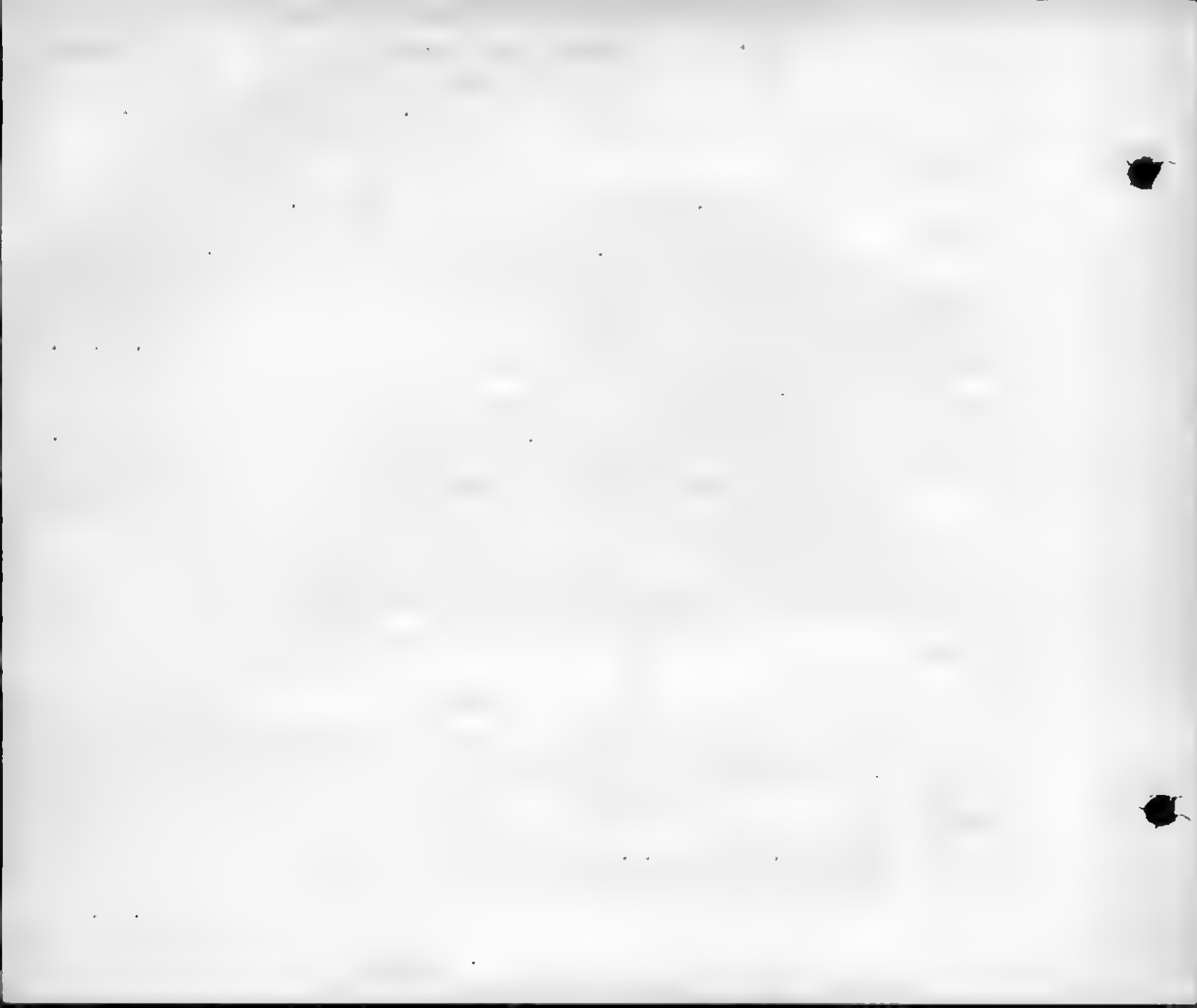
Reg. Dist. No.

08786

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN 1b 5yrs		d. STREET ADDRESS 227 Blakeney Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 227 Blakeney Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James S. Hall		4. DATE OF DEATH Month Day Year Aug. 15 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1882
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James S. Hall		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Herbert Ganzmann		Address 227 Blakeney Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x CANCER, STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 7, 1959, to AUG. 15, 1959, that I last saw the deceased alive on AUG. 15, 1959, and that death occurred at 5a. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gilbert E. Rudman M.D.		ADDRESS (Street, city or town, state) 2517 W. Baltimore St.	
PHYSICIAN'S NAME (Type) Gilbert E. Rudman, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-59	
22c. NAME OF CEMETERY OR CREMATORY Wallkill		22d. LOCATION (City, town, or county) (State) Phillipsburg, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		ADDRESS Catonsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 18 '59			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8821

## CERTIFICATE OF DEATH

08787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 Thornhill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>E.</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Valentine Schoenig</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Mueller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Frederick Hall</u> ADDRESS <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>Hypertensive heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/1/59</u> , 19 <u>59</u> , to <u>8/17/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/17/59</u> , and that death occurred at <u>9:29 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wahlan Pearson</u> M.D.		DATE SIGNED <u>8/17/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>AUG 19 59</u>	24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>

MEDICAL CERTIFICATION



8822

## CERTIFICATE OF DEATH

06788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr22dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>6114 Central Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Hall</b>			4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1884</b>		9. AGE (in years last birthday) <b>74</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Governor Winsor</b>		
14. MOTHER'S MAIDEN NAME <b>Elizabeth Langley</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		
16. SOCIAL SECURITY NO. <b>Unknown</b>			17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic nephrosclerosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>July 13, 1956</b> to <b>Aug. 7, 1959</b> , that I last saw the deceased alive on <b>Aug. 7, 1959</b> , and that death occurred at <b>12:30 a. m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>8-7-59</b>					
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.					
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>	
22d. LOCATION (City, town, or county)		(State) <b>Upper Marlboro Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8823

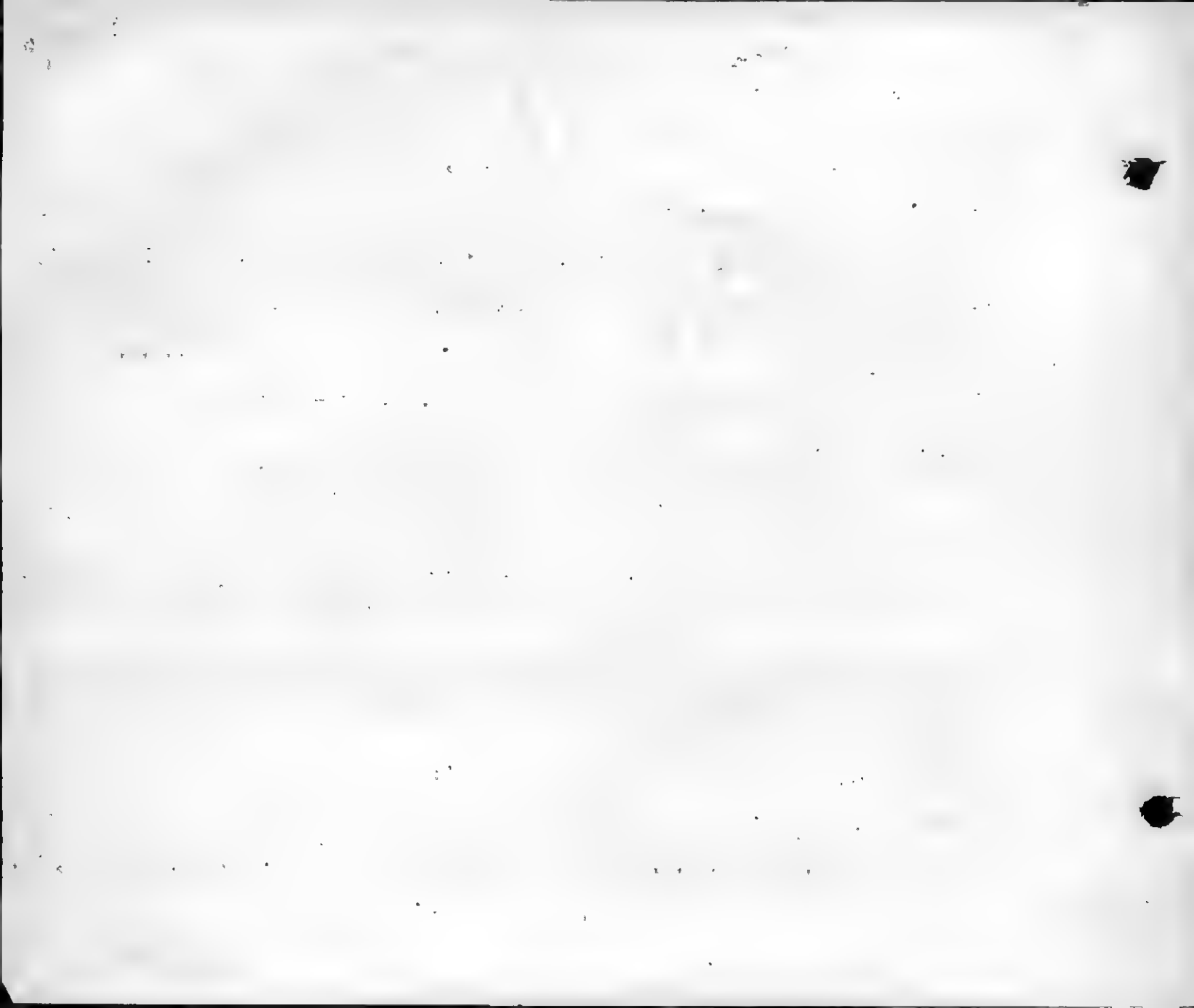
CERTIFICATE OF DEATH

Reg. Dist. No.

08789

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walton</u> Middle <u>Wallace</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/07</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William I. Hall - deceased</u>	
14. MOTHER'S MAIDEN NAME <u>Mary G. Walton - deceased</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia sub-acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxemia -</u> DUE TO (c) <u>Arterio-sclerosis, generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>10 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (COND T ON GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>  </u> 19 <u>  </u> to <u>8/19/59</u> 19 <u>  </u> , that I last saw the deceased alive on <u>8/19/59</u> 19 <u>  </u> , and that death occurred at <u>7:40a</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		DATE SIGNED <u>8/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		Rosewood Training School, Owings Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 19, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>  </u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newman</u>	ADDRESS	24a. REC'D BY REGISTRAR DATE <u>AUG 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8824

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. COUNTY <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>BALTIMORE CITY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. STREET ADDRESS <b>2005 MONTEBELLO</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First Middle Last		4. DATE OF DEATH <b>HARMAN</b> Month Day Year <b>9 9 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-94</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>05</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH-STEEL</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GRAT HARMAN</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE WHITE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>236-10-3436</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULMONARY TUBERCULOSIS</b> DUE TO (b) <b>COR PULMONALE</b> DUE TO (c) <b>COR PULMONALE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-7</b> , 19 <b>57</b> to <b>8-9</b> , 19 <b>59</b> that I last saw the deceased alive on <b>8-9</b> , 19 <b>59</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hartwell Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Hartwell, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Rd.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cuthbert J. Hume</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD  
BALTIMORE (CT)  
2002 MONTEBELLO

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HARMAN

WILLIAM

4-23-44

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M

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MAINTENANCE BETH-STEEL VIRGINIA

GRAT HARMAN HATTIE WHITE

200-10345

MC

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FOR ADVANCED PLACEMENT  
TUBERCULOSIS

CCR PLACEMENT

27

9-8-44

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9-9-44

8825

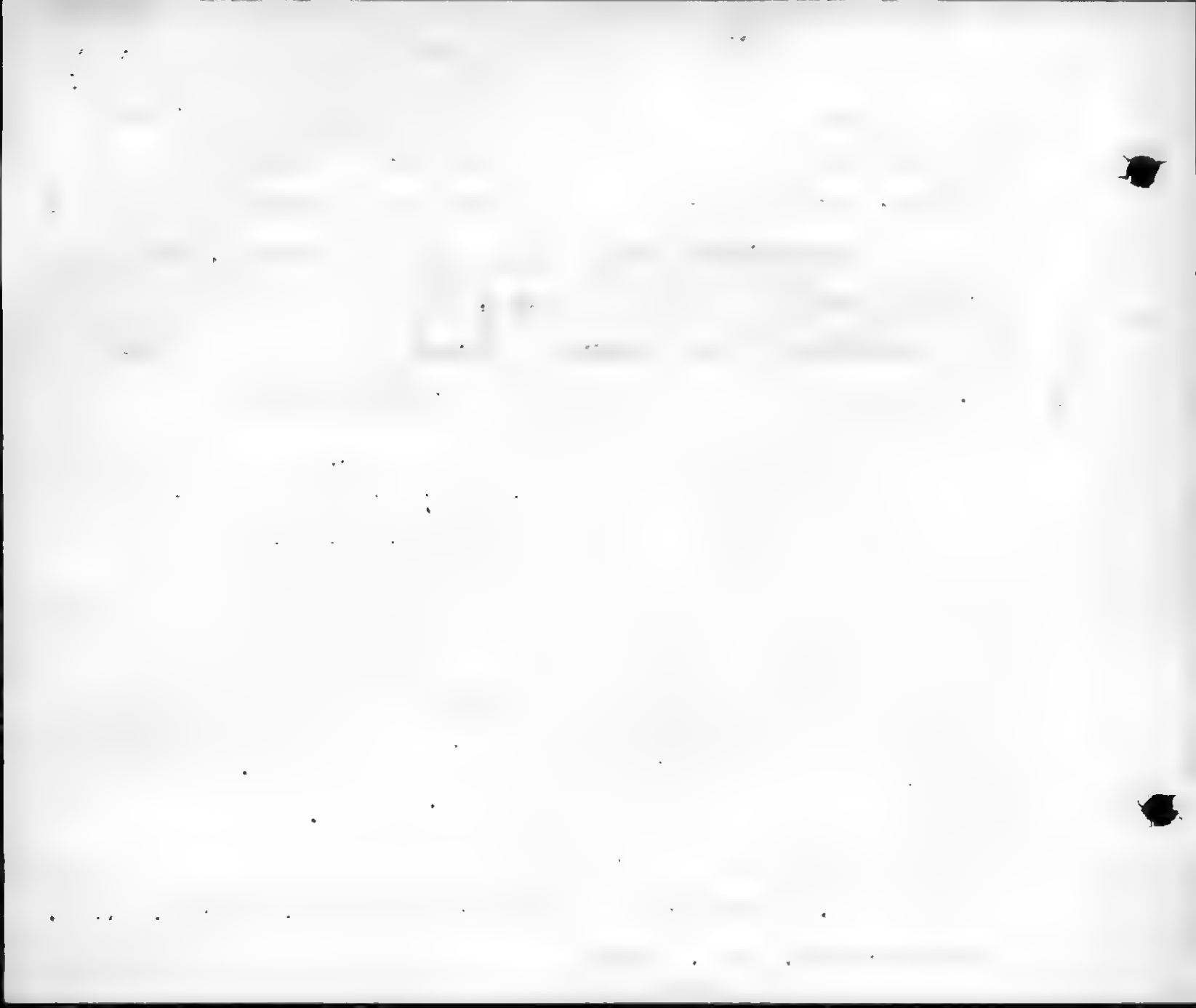
## CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bellona &amp; Division Avenues</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM ELSWORTH MARR</b>		4. DATE OF DEATH Month Day Year <b>August 7, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horse Transportation</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. George Marr</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Dearholt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. INFORMANT Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Coronary artery thrombosis</b> <b>420.1</b> DUE TO (b) <b>Coronary artery atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18. INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>.5 hr</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1955</b> to <b>Aug 7, 1959</b> that I last saw the deceased alive on <b>July 15, 1959</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Lutherville, Md.</b> DATE SIGNED <b>5/11/59</b>			
ACTUAL SIGNATURE <b>G. T. Gilmore</b> M.D.			
PHYSICIAN'S NAME (Type) <b>G. T. GILMORE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. H. P. Jones</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

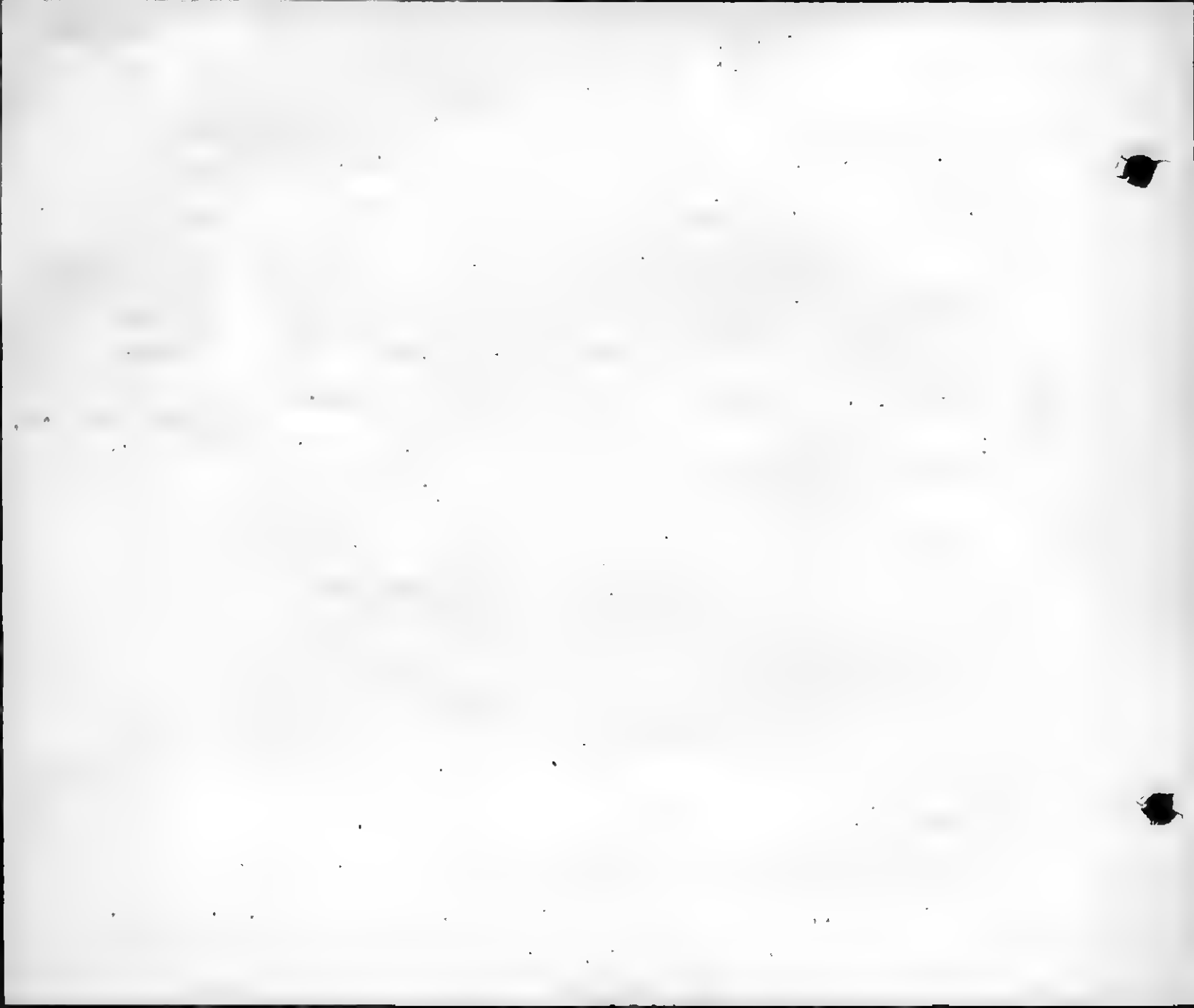
8825

## CERTIFICATE OF DEATH

08792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Catonsville</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forrest Haven Nursing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Mary</u> Last <u>Hartman</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bartholemew Cashman</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Hanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. ADDRESS <u>Pikesville 8, Md.</u>		18. ADDRESS <u>Mr. Harry J. Hartman, 3 Warren Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u>PULMONARY EMBOLISM</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>59</u> , to <u>8/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/27</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		ADDRESS (Street, city or town, state) <u>5800 Edmonson Rd</u> DATE SIGNED <u>8/29/59</u>	
PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>		DATE <u>28/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 31, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>





8827

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8604 Harford Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Lee</u> Last <u>Hartman</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Laura Harker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>413-10-1010</u>		INFORMANT <u>Anna Hartman</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marked as cause of death</u> DUE TO (b) <u>161X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Marked as cause of death</u> DUE TO (b) <u>161X</u> DUE TO (c) <u>Marked as cause of death</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:05</u> to <u>19:50</u> on <u>5 Aug</u> 19 <u>59</u> that I last saw the deceased alive on <u>5 Aug</u> 19 <u>59</u> , and that death occurred at <u>11 A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard Goodman</u> M.D.				ADDRESS (Street, city or town, state) <u>8604 Harford Rd Baltimore Md</u> DATE SIGNED <u>6 Aug 59</u>			
PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Ru.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY IN CHARGE, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

8828

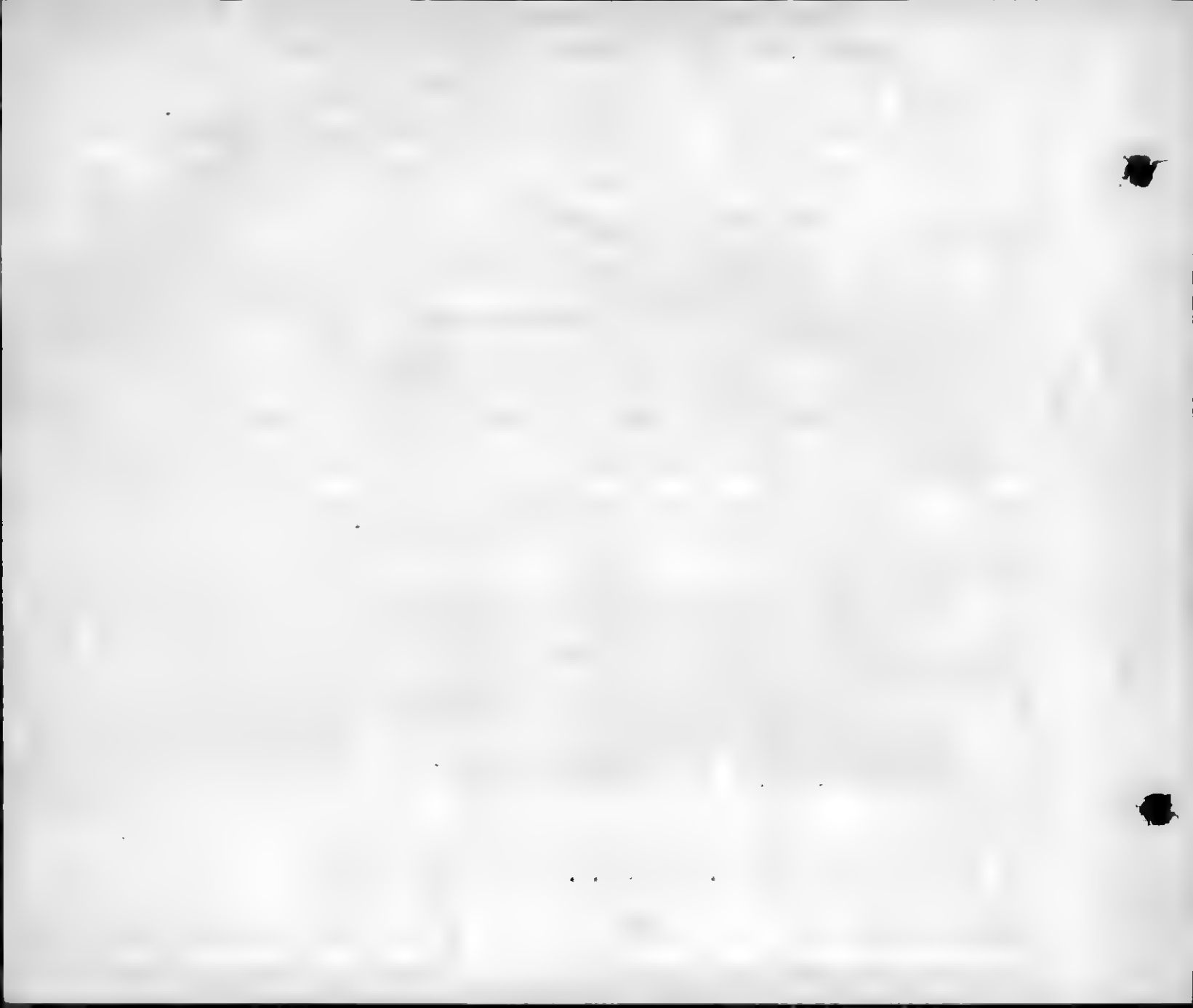
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>213 Courtland Avenue</b>				d. STREET ADDRESS <b>213 Courtland Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>PHILIP</b> Last <b>HEBERT</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/6/59</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <b>9-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W. &amp; M. U. S. School</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <b>SEP 10 59</b>		<b>Charles S. Petty</b>	

MEDICAL CERTIFICATION



8829

CERTIFICATE OF DEATH

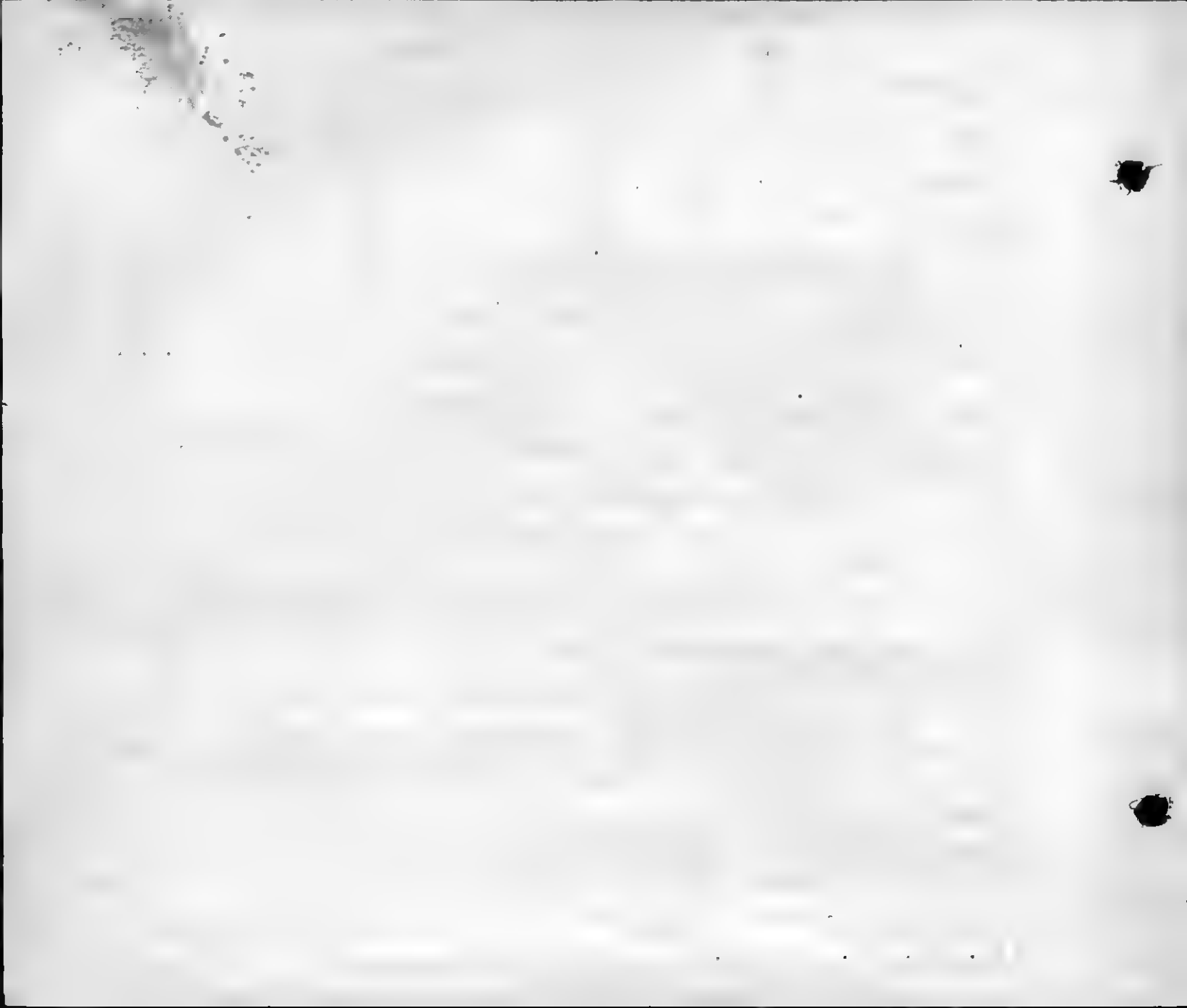
08794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aged Women's &amp; Aged Men's Home</b> <b>615 Chestnut Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 14 Baltimore 29</b> <b>3311</b>	
f. STREET ADDRESS <b>327-C Collins Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence M. Henderson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1883</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard J. Warnick</b>		14. MOTHER'S MAIDEN NAME <b>Melvina McKean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Aged Women's &amp; Aged Men's Home, Towson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture abdominal aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic lesions - vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>76 hrs</b> <b>5 yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January</b> , 1954, to <b>August 15</b> , 1959, that I last saw the deceased alive on <b>August 14</b> , 1959, and that death occurred at <b>11:50</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>H-E-33rd St Baltimore</b> DATE SIGNED <b>August 17, 1959</b>			
ACTUAL SIGNATURE <b>Newland E. Day</b> M.D.		PHYSICIAN'S NAME (Type) <b>Newland Edward Day M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-18-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8830**  
**CERTIFICATE OF DEATH**

08795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7012 York Road</b>		d. STREET ADDRESS <b>7012 York Road #12</b>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>B.</b> Last <b>HEROLD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Alexander Bond</b>		14. MOTHER'S MAIDEN NAME <b>Cora McAfee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. H. Irving Mettee-7012 York Road #12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> DUE TO <b>With Metastases to Liver</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 19 57</b> to <b>Aug 5 19 59</b> that I last saw the deceased alive on <b>Aug 5 19 59</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alfred J. [Signature]</b> M.D.		DATE SIGNED <b>Aug 1 19 59</b>	
PHYSICIAN'S NAME (Type) <b>3033 W. North Ave</b>		<b>Paul J. [Signature]</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REG'D BY REGISTRAR <b>AUG 1 19 59</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OF PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

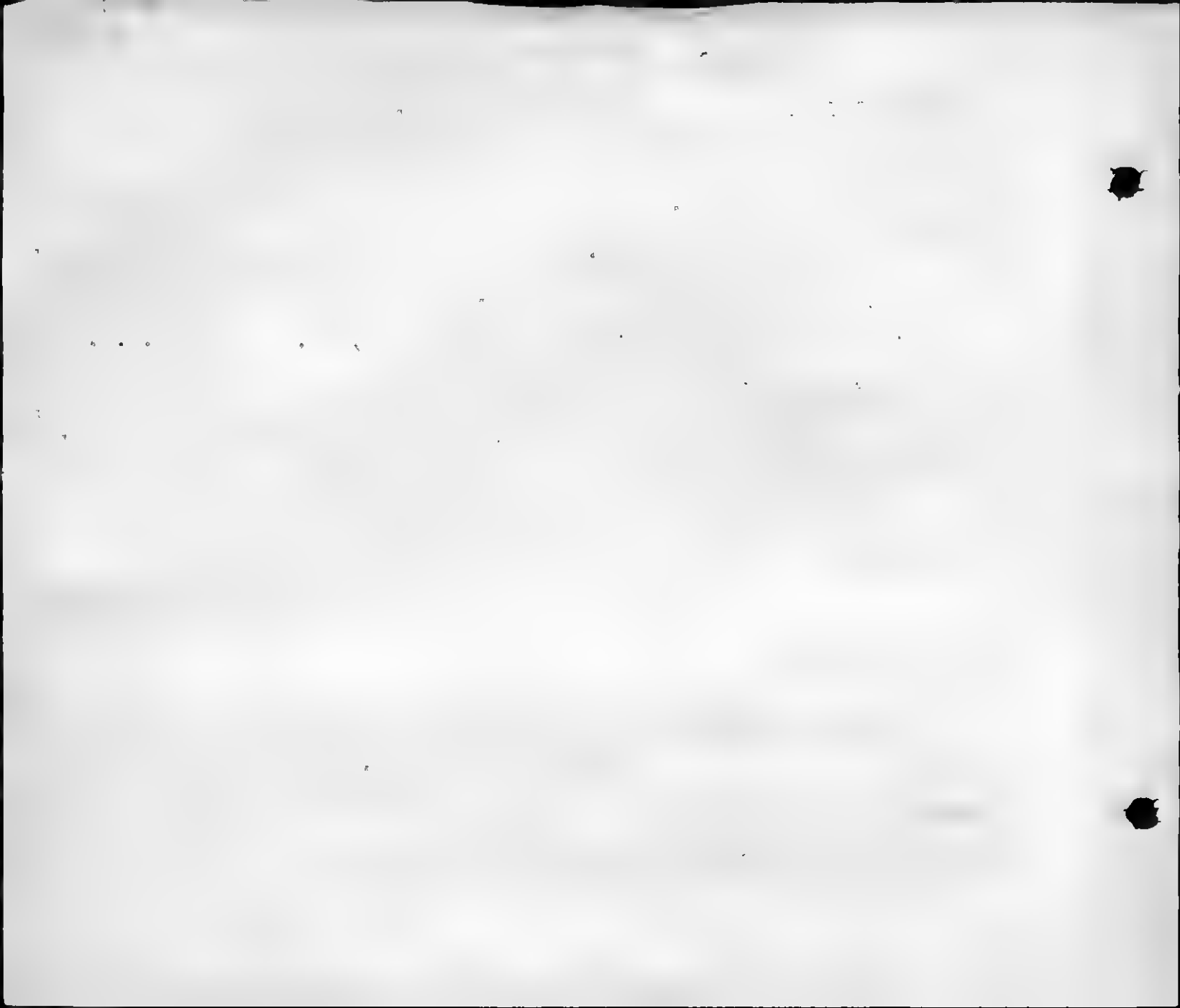
CERTIFICATE OF DEATH

Reg. Dist. No.

08796

8831

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1780 Joan Ave.</b>				d. STREET ADDRESS <b>3062 Hermitage Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>J.</b> Last <b>HESSION</b>				4. DATE OF DEATH Month <b>August</b> Day <b>28</b> , Year <b>1959</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1889</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Miner.</b>		11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Hession</b>				14. MOTHER'S MAIDEN NAME <b>Unknown.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elvera M Pohlner</b> Address <b>Towson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>523.0</b> DUE TO <b>Senile Pulmonary Fibrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sclerosis</b> (c) <b>Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>MINOOKA</b>		(County) <b>PA.</b>	(State)
21. I certify that I attended the deceased from <b>8-21-59</b> to <b>8-28-59</b> , that I last saw the deceased alive on <b>8-25-59</b> , and that death occurred at <b>4:08 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3062 Hermitage Ave. Easton, Pa.</b> DATE SIGNED <b>8/28/59</b>							
ACTUAL SIGNATURE <b>Joseph F. Pihl</b> M.D.		PHYSICIAN'S NAME (Type) <b>Joseph F. Pihl</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEM.</b>		22d. LOCATION (City, town, or county) <b>MINOOKA</b>		(State) <b>PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Geller</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>				24a. REC'D BY REGISTRAR <b>DA SEP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>	



8832

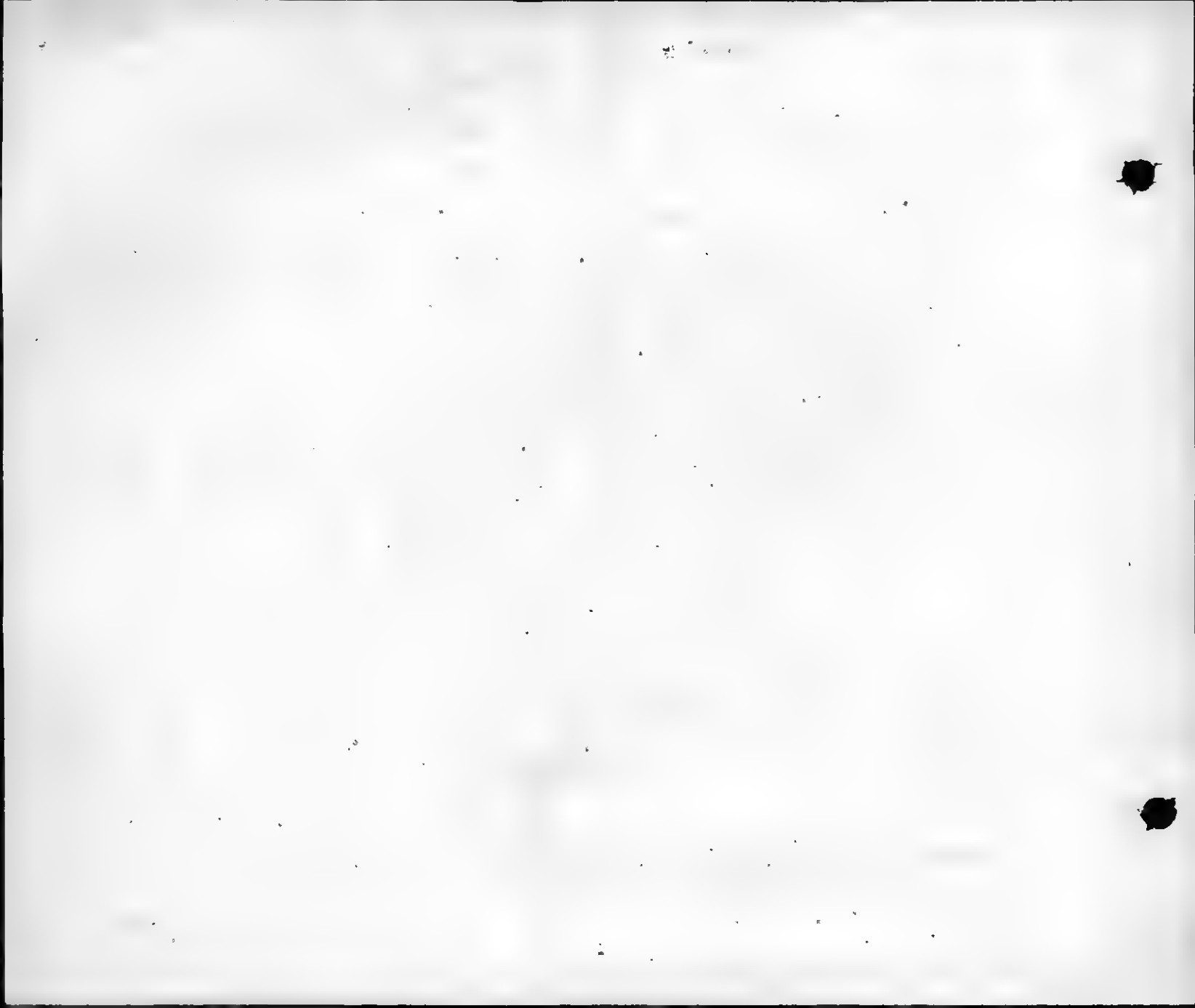
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>				c. LENGTH OF STAY IN 1b <b>X Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 16 Box 297</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>H.</b> Last <b>Hicks</b>				4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1885</b>	
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>		IF UNDER 24 HRS Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor-Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Russell W. Hicks</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pass</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>413-09-2241</b>			
17. INFORMANT <b>Mrs. Earl Steiner</b>				Address <b>Rt. 16 Box 297 20</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - (ASH)</b> DUE TO (c) <b>15 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Pulmonary Emphysema</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JAN 8/10</b> , 19 <b>52</b> , to <b>8/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/10</b> , 19 <b>59</b> , and that death occurred at <b>1:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph J. Cameron</b>				ADDRESS (Street, city or town, state) <b>1515 Martin Blvd - Baltimore, Md.</b>			
DATE SIGNED <b>8/28/59</b>							
PHYSICIAN'S NAME (Type) <b>JOSEPH J. CAMERON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>Aug. 28, 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>				22d. LOCATION (City, town, or county) (State) <b>Sweet Water, Tennessee</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Larahn Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>			
24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Hines</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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15M 9/58

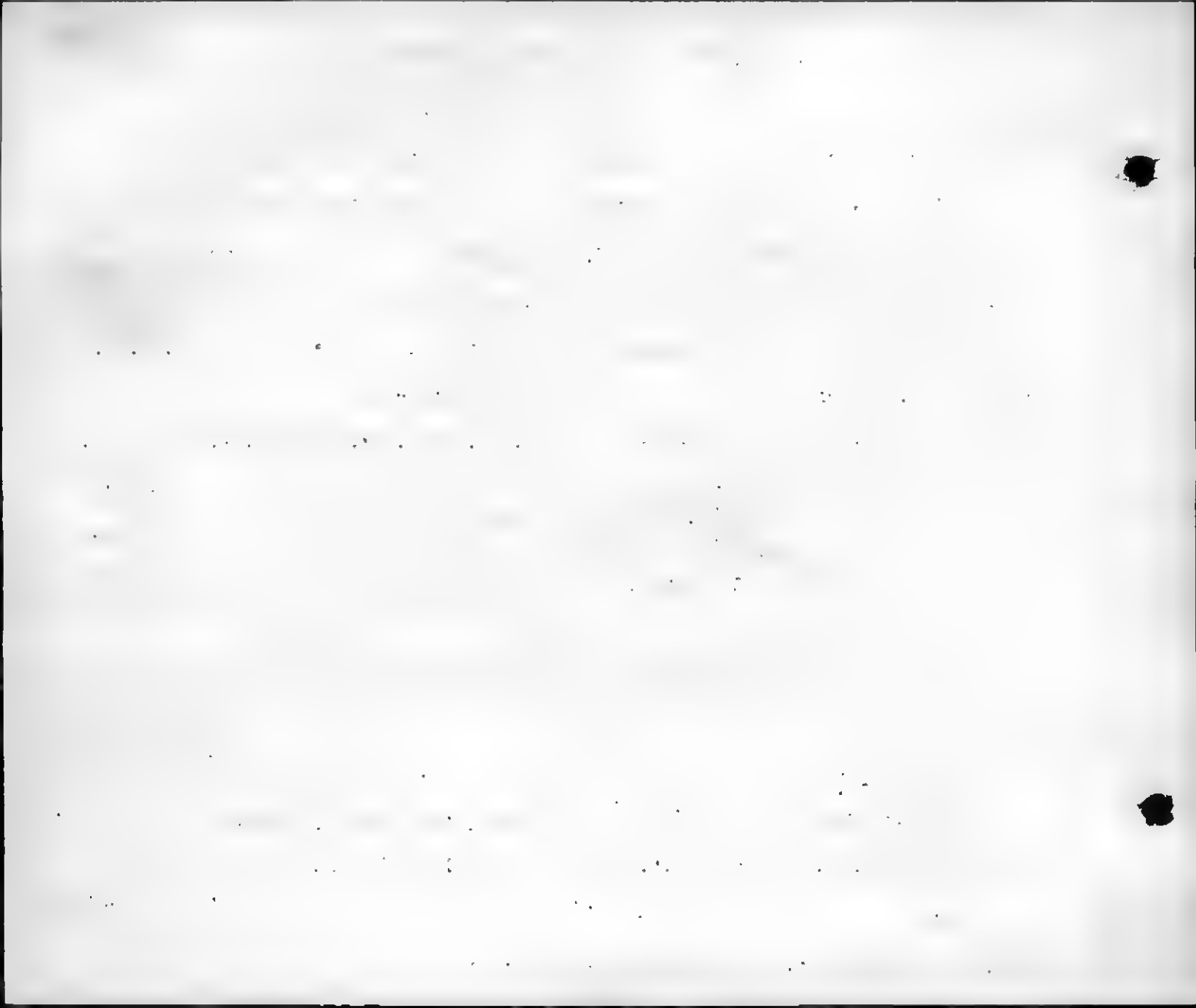
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8833 CERTIFICATE OF DEATH

08798

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2503 Washington Boulevard</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>AUBREY</b> Middle <b>G.</b> Last <b>HOOPER</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>5</b> Year <b>19 59</b>	
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 1, 1916</b> <b>9. AGE</b> (In years, last birthday) <b>43</b> <b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Helper</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bakery</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Walter D. Hooper</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Neveker</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-10-6920</b> <b>INFORMANT</b> <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>CHRONIC GLOMERULONEPHRITIS</b> PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CARCINOMA, LUNG</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>OLD</b> <b>RECENT</b> <b>UNKNOWN</b>	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>August 1</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>11:15 PM</b> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>John W. Crawford</b>		<b>ADDRESS</b> (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> <b>DATE SIGNED</b> <b>8/6/59</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND</b>	
<b>22a. BURIAL, CREMATION, REMOVAL.</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8-10-59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Meadowridge Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Washington Blvd., Balto. Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc.</b> <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 10 '59</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8834

## CERTIFICATE OF DEATH

Reg. Dist. No.

08799

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>				c. LENGTH OF STAY IN 1b <b>110 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>LEE</b> Last <b>HOWARD</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 9, 1893</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		11. IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		12. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevadore</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Loading Cargo</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Elijah G. Howard</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Carroll</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b> (If give year or dates of service) <b>WW I</b>			
16. SOCIAL SECURITY NO <b>215-05-5926</b>				17. INFORMANT Address <b>Clin. Records, VAH, Balto. 18, Md., Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONVULSIVE SEIZURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARDIOVASCULAR ACCIDENT</b> <b>UNKNOWN</b>							
(c) <b>GENERALIZED ARTERIOSCLEROSIS</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONIA</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office b. d. g., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 6</b> , 19 <b>59</b> , to <b>August 24</b> , 19 <b>59</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>VAH, BALTO. MD., FORT HOWARD DIVISION</b> DATE SIGNED <b>8/24/59</b>			
PHYSICIAN'S NAME (Type) <b>JAMES R. POWDER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy Wilson</b>				ADDRESS <b>601 Hamburg, Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chilton &amp; Hines</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





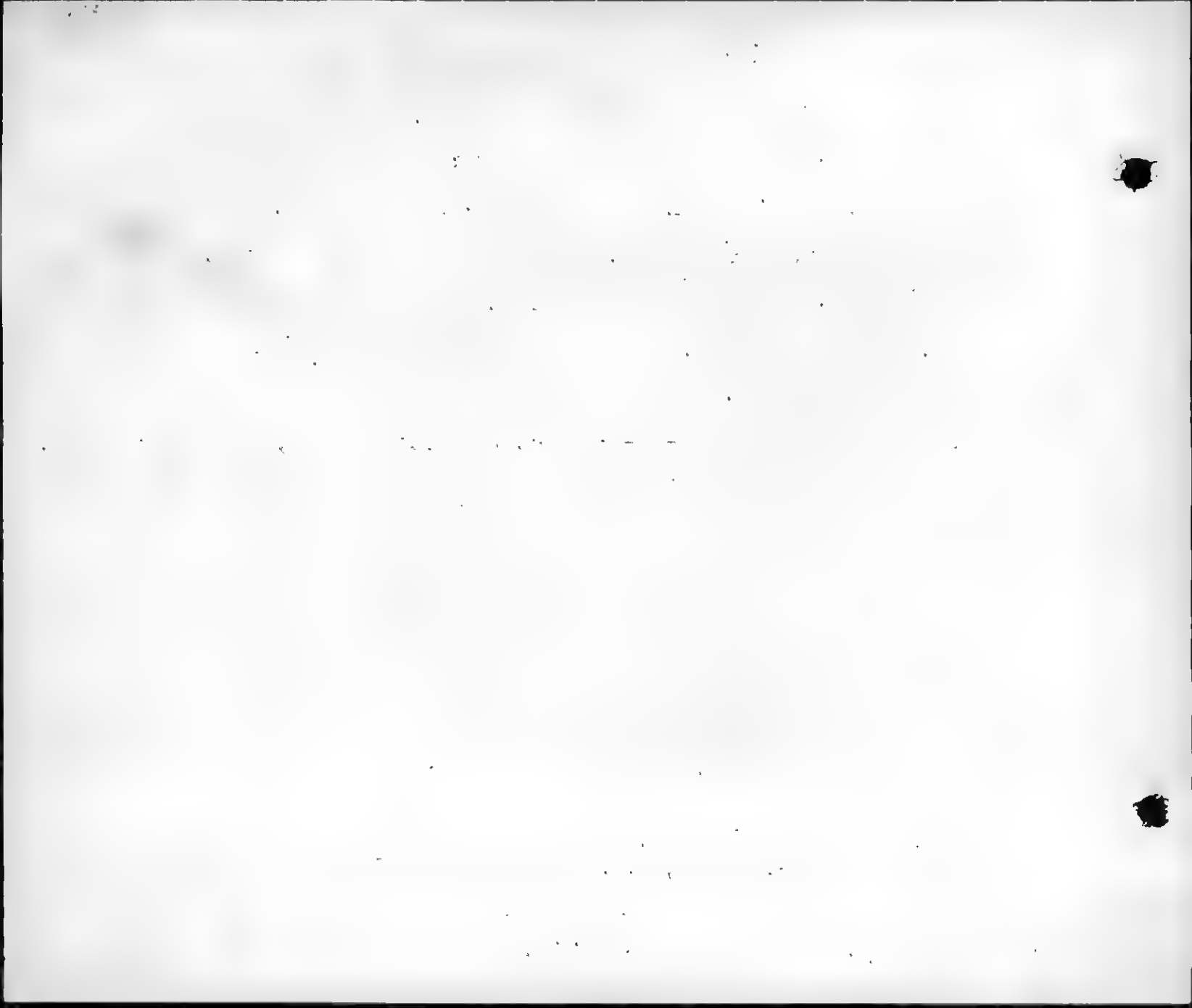
8835

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3012 Taylor Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Conrad</u> Middle <u>H.</u> Last <u>Huether</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sherwood Oil Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Huether, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-8500</u> Mr. Douglas Huether, 6008 Roland Ave.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 AUGUST 1959</u> to <u>15 AUGUST 1959</u> , that I last saw the deceased alive on <u>13 AUG</u> , 19 <u>59</u> , and that death occurred at <u>7 A</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John B. DeHoff</u> M.D.			
PHYSICIAN'S NAME (Type) <u>John B. DeHoff, M.D.</u>		Loch Raven Shopping Center	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08801

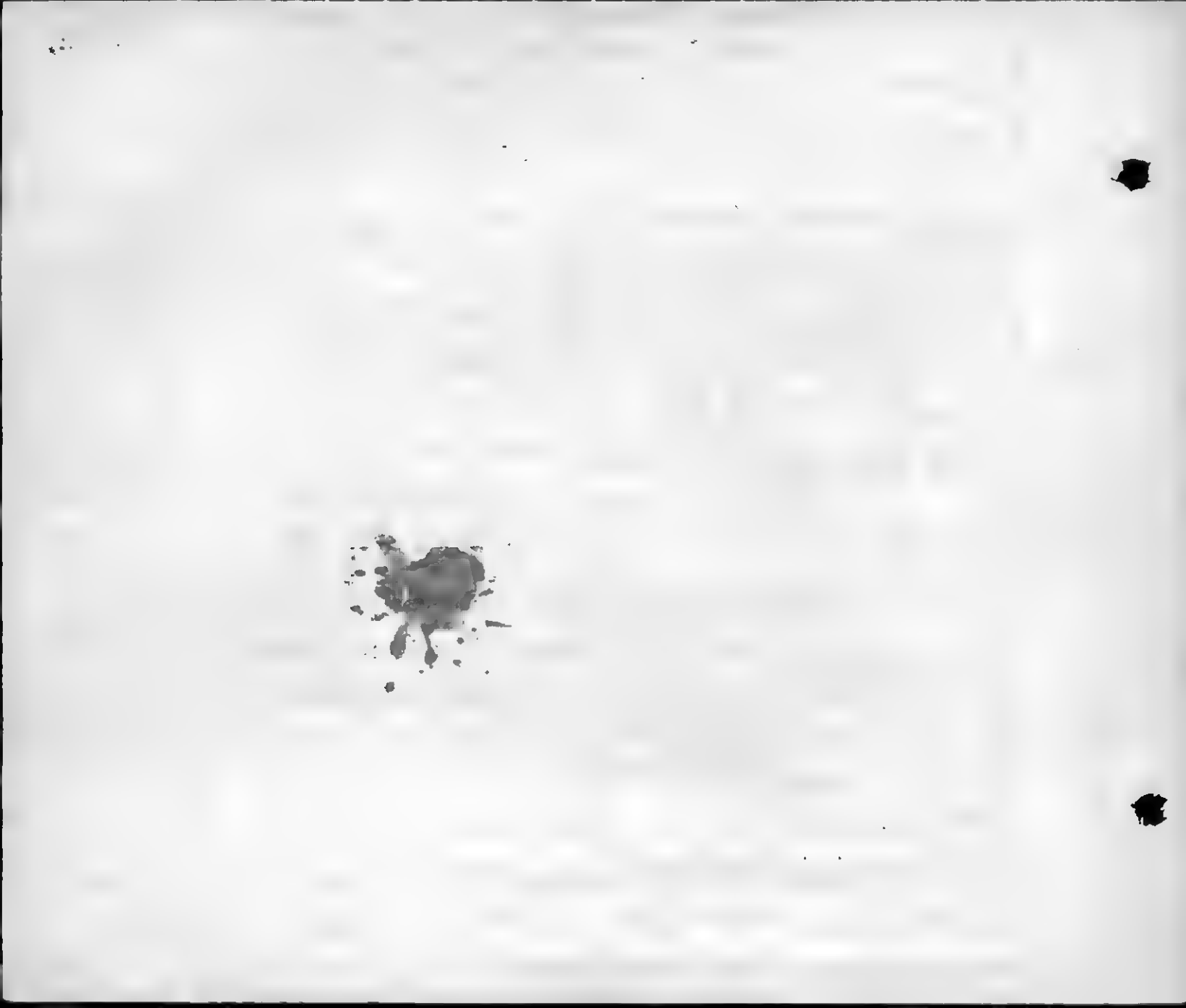
8836

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701 Old Home Rd.</u>		d. STREET ADDRESS <u>701 Old Home Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence E. Jacques</u>		4. DATE OF DEATH <u>August 8, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lieutenant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Police</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Columbus Jacques</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Leona A. Jacques</u>		Address <u>701 Old Home Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1959</u> to <u>Aug. 8, 1959</u> , that I last saw the deceased alive on <u>3:15 pm 8/8, 1959</u> , and that death occurred at <u>3:30 pm</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Baylston D. Smith</u>		DATE SIGNED <u>6900 Hanford Rd.</u>	
PHYSICIAN'S NAME (Type) <u>B. D. Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassakin Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Evans</u>	
ADDRESS <u>7401 Belair Rd.</u>		DATE <u>Aug 11 '59</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

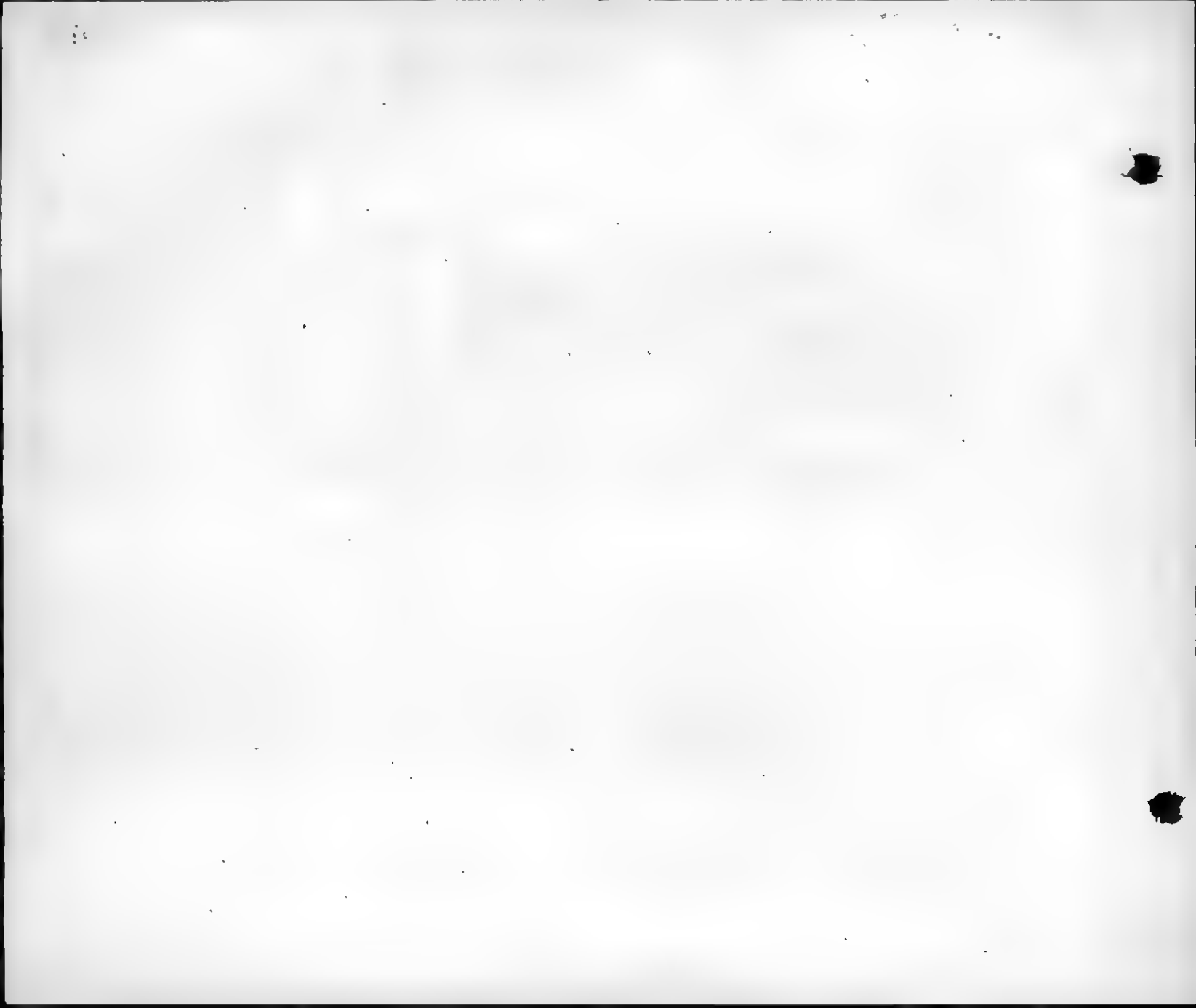
8837

CERTIFICATE OF DEATH

Reg. Dist. No.

08802

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>70</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines 16 Fustling Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna James</u>		4. DATE OF DEATH <u>Aug. 2/59</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 9, 1885</u>
9. AGE (In years, lost birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hochschild Kohn</u>	
11. BIRTHPLACE (State or foreign country) <u>W. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Katherine Heane</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Miss Dorothy James 1016</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		6. hr. 10 yr (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-23-1957</u> to <u>8-2-1959</u> , that I last saw the deceased alive on <u>8-1-1959</u> , and that death occurred at <u>10:40 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Ballager</u> M.D.		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>8-3-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Ballager</u>		<u>Baltimore 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 4/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. 104101 Emondson</u>		24a. REC'D BY REGISTRAR <u>AUG 4 '59</u>	
ADDRESS <u>104101 Emondson</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

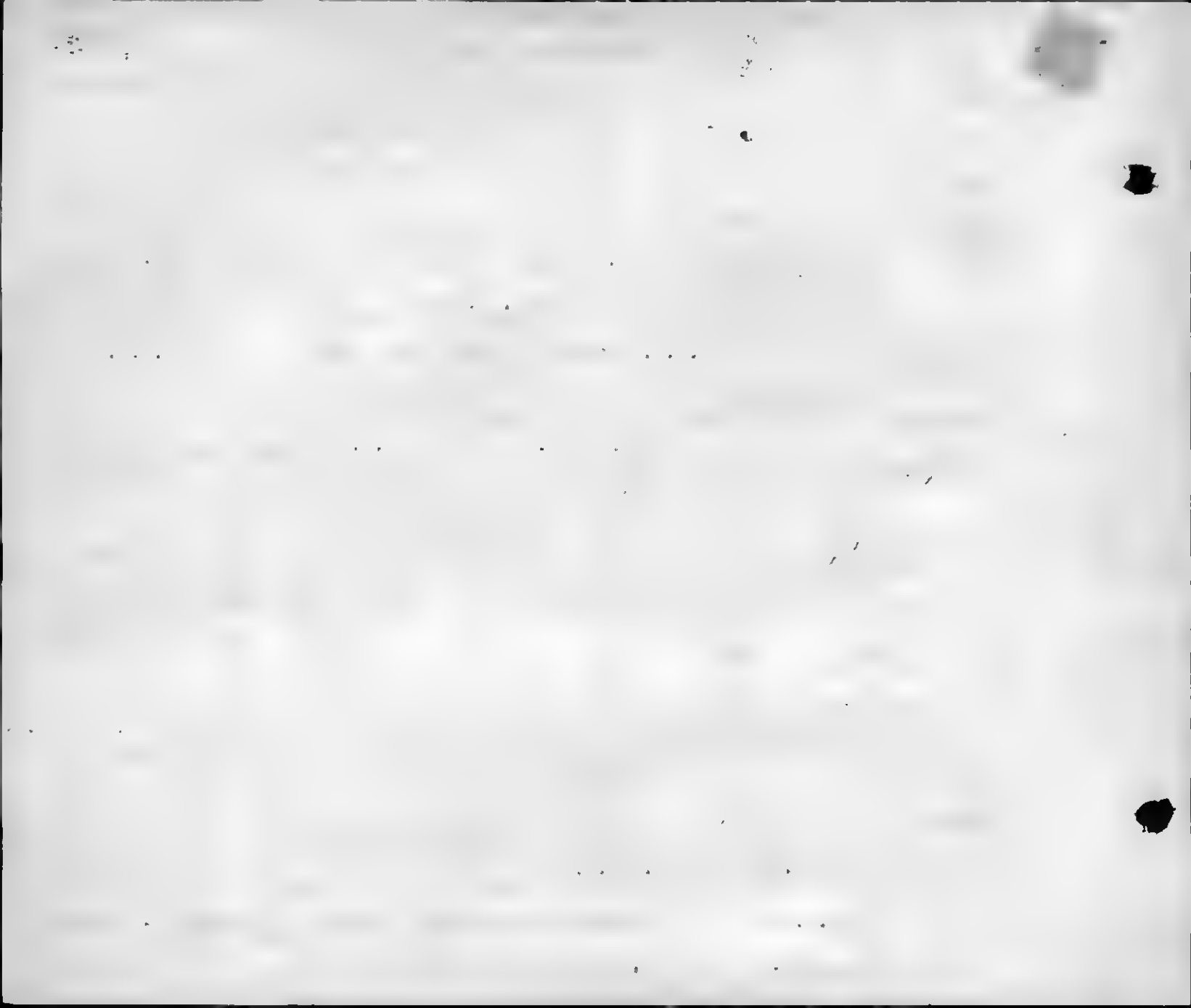
8838

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		Item 20b, Film G-246 8/12/59		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Iowa		b. COUNTY 53x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1407 Eastern Avenue		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkersburg		d. STREET ADDRESS 53x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1407 Eastern Avenue				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH		Middle J.		Last JANS		4. DATE OF DEATH Month August	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 10, 1940	
9. AGE (In years last birthday) 19		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY U.S.S. Cadmus		11. BIRTHPLACE (State or foreign country) Waverly, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dick Jans		14. MOTHER'S MAIDEN NAME Mildred (Unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Dick Jans R.R.#2 Delwin, Iowa		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard from Coast Guard Boat					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 8/2/1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Off Breezy Point, Middle River, Balto. Co., Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.						DATE SIGNED 8/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) Fairbanks (Fayette Co.) Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE AUG 10 '59		24b. REGISTRAR'S SIGNATURE Charles S. Krouse	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8839

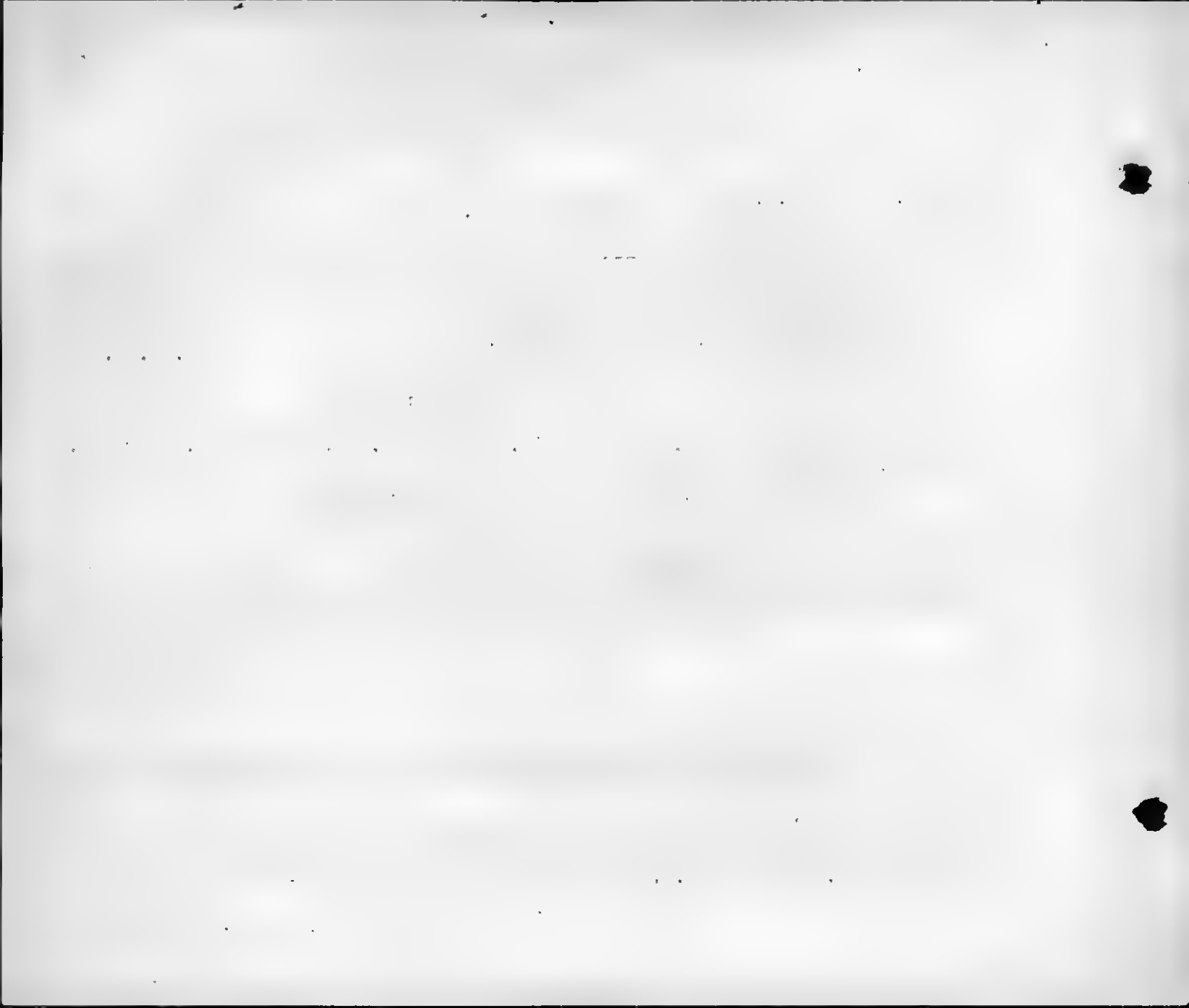
## CERTIFICATE OF DEATH

08804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>511 W. Hoffman Street (1)</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLIOTT JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>August 13 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1893</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Union South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dan Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Fannie MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>Unk.</b>	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, RIGHT CEREBRUM</b> <b>BRONCHOGENIC CARCINOMA RIGHT LUNG</b> <b>BRONCHOPNEUMONIA</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>ANEURYSM, THORACIC AORTA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 1/2 years</b> <b>2 days</b> <b>unknown</b> <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 12, 1959</b> to <b>August 13, 1959</b> and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above <b>John W. Crawford</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 8/14/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burlington Phillips, 1808 N. Monroe St.</b>		24a. REC'D BY REGISTRAR <b>Aug 17 59</b>	
ADDRESS <b>Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by 1, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMQ. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08805
8840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>3713 St. Margaret Street</u>			e. IS RE BURIAL ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Louise</u> Last <u>Johnson</u>					4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>19 59</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11, 1921</u>		9. AGE (In years, last birthday) <u>38</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Stephen Harrison</u>					14. MOTHER'S MAIDEN NAME <u>Nellie Fields</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>193.0 Congestive heart failure</u>										
DUE TO (b) <u>Intracerebral pressure</u>										
DUE TO (c) <u>Encephalomalacia of left cerebral peduncle and temporal tip due to trauma/ Brain Glioma temporal lobe</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] <u>History of fall on street at any time at all; last fall occurred within last ten days</u>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>unknown</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>ten days</u> (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>George M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) <u>E. kridge, Md</u> (State)		DATE SIGNED <u>8-12-59</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>				



1  
A

8841

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08806

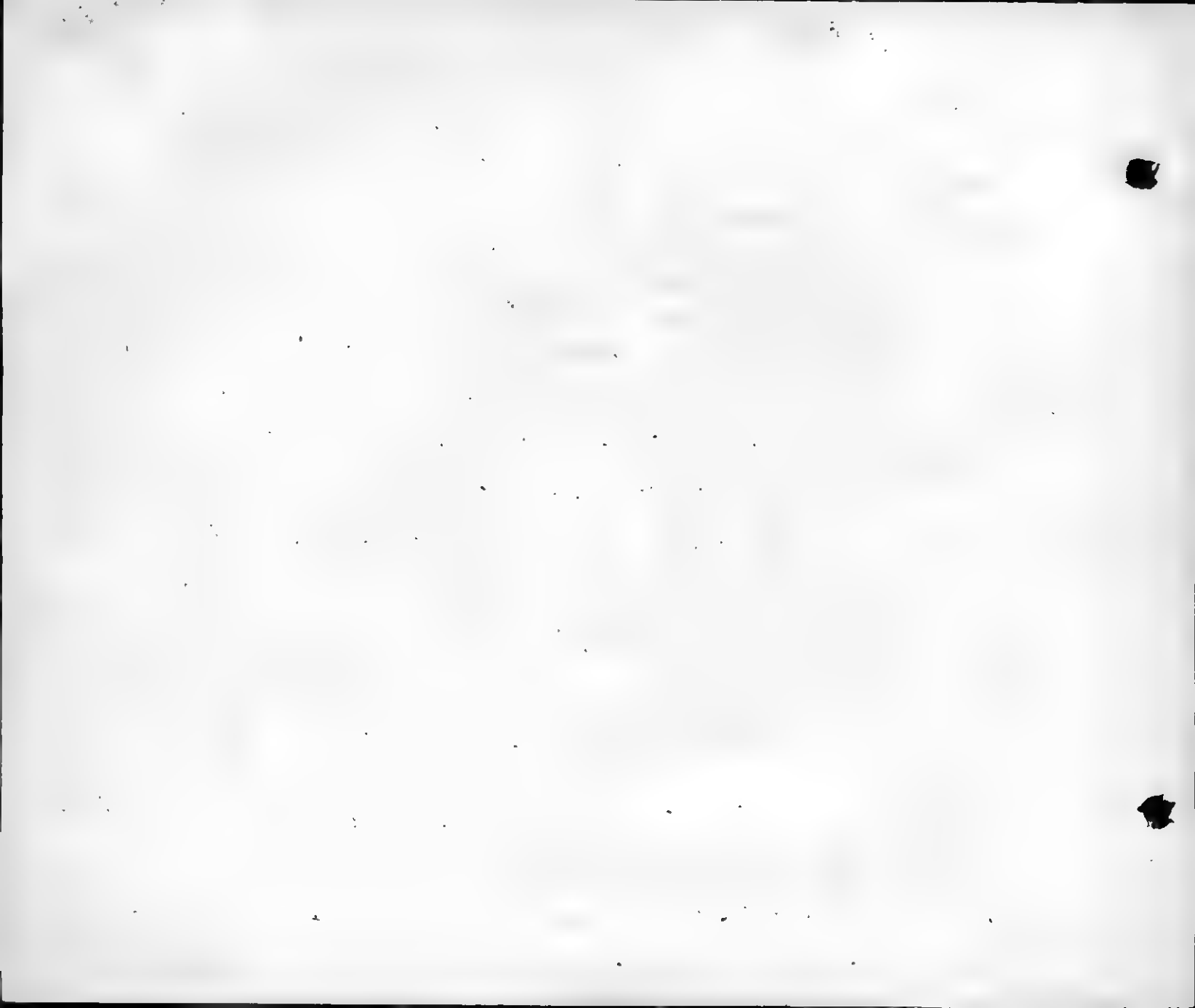
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MANOR</u>				c. LENGTH OF STAY IN 1b <u>10 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5921 MONTGOMERY ST.</u>				d. STREET ADDRESS <u>5921 MONTGOMERY ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LOUIS JONES</u>				4. DATE OF DEATH Month Day Year <u>AUG. 7 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 15, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TACKLER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRY GOODS</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>GRACE JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>216-501-5684</u>			
17. INFORMANT <u>MARGARET JONES</u> Address <u>5921 MONTGOMERY ST.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Hypertension of V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>49X</u> (b) <u>100Y</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Pyelonephritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>57</u> , to <u>8/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Adrian D. Haccius</u> M.D.				ADDRESS (Street, city or town, state) <u>9300 Liberty H.C. Rd</u> DATE SIGNED <u>8/8/59</u>			
PHYSICIAN'S NAME (Type) <u>Francis H. Miller</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO. L. Schwab, FUNERAL</u> ADDRESS <u>2101 Frederick Ave.</u>				24a. REC'D BY REGISTRAR <u>Aug 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Jones</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



8842

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08807

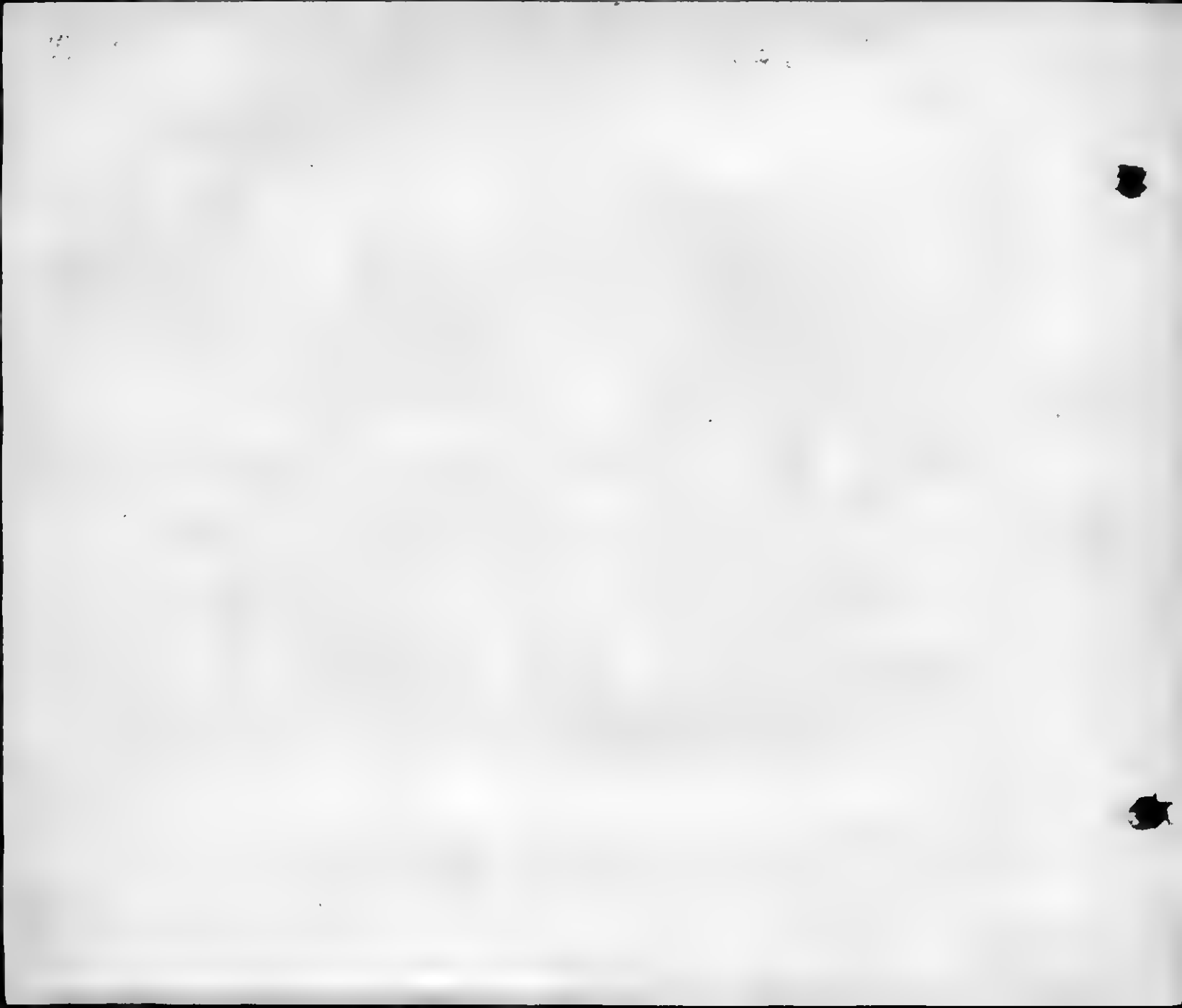
Item 4, Film G-253 12, 23/59.cac.

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>few hours</u>		d. STREET ADDRESS <u>116 W University Pkwy @</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>508 Overbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roland Hall Jones</u>		4. DATE OF DEATH <u>Aug 9, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3/1881</u>
9. AGE (in years last birthday) <u>77</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>John W Jones</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>25-03-4444</u>	
17. INFORMANT <u>Walter F. Medall</u>		Address <u>116 W University Pkwy @</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u>			
(c) <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 minute</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dirk Van Peenen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dirk Van Peenen, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Balti 7</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Morrell</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>108 W York - 1</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>AUG 11 1959</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

## CERTIFICATE OF DEATH

08808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>417 Chestnut Ave.</b>				d. STREET ADDRESS <b>417 Chestnut Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AIMEE W.</b> Middle <b>KAESSMANN</b> Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>18,</b> Year <b>19 5 9</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 15, 1875</b>	
9. AGE (In years lost birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>—</b>							
13. FATHER'S NAME <b>William R. Will</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Sinclair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>Mr. Harold R. Manakee - 417 Chestnut Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April</b> , 19 <b>51</b> to <b>Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 18</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.</b> M. from the causes and on the date stated above.				DATE SIGNED			
ACTUAL SIGNATURE <b>William G. Helfrich M.D.</b>				ADDRESS (Street, city or town, state) <b>5006 Roland Ave Balt 10</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Lickner 4800 N. ...</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8844

## CERTIFICATE OF DEATH

08809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN TB <b>24 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP.</b>		d. STREET ADDRESS <b>1409 E. CLEMENT ST.</b>	
3. NAME OF DECEASED (Type or print) <b>DIMITRI</b>		4. DATE OF DEATH <b>AUGUST 30 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. &amp; OHIO R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>BULGARIA</b>
12. FATHER'S NAME <b>(UNKNOWN)</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		17. INFORMANT <b>RECORDS OF</b> Address <b>SPRING G. S. HOSP.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>4 yrs</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>(b) DUE TO</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS + 14 YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>+ 10 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/30/1959</b> to <b>8/30/1959</b> , that I last saw the deceased alive on <b>8/30/1959</b> , and that death occurred at <b>6:55 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Isadore Tuck, M.D.</b>		DATE SIGNED <b>Aug. 30 '59</b>	
PHYSICIAN'S NAME (Type) <b>Isadore Tuck, M.D.</b>		ADDRESS (Street, city or town, state) <b>Catonville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR FUNERAL HOME: This certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8845

## CERTIFICATE OF DEATH

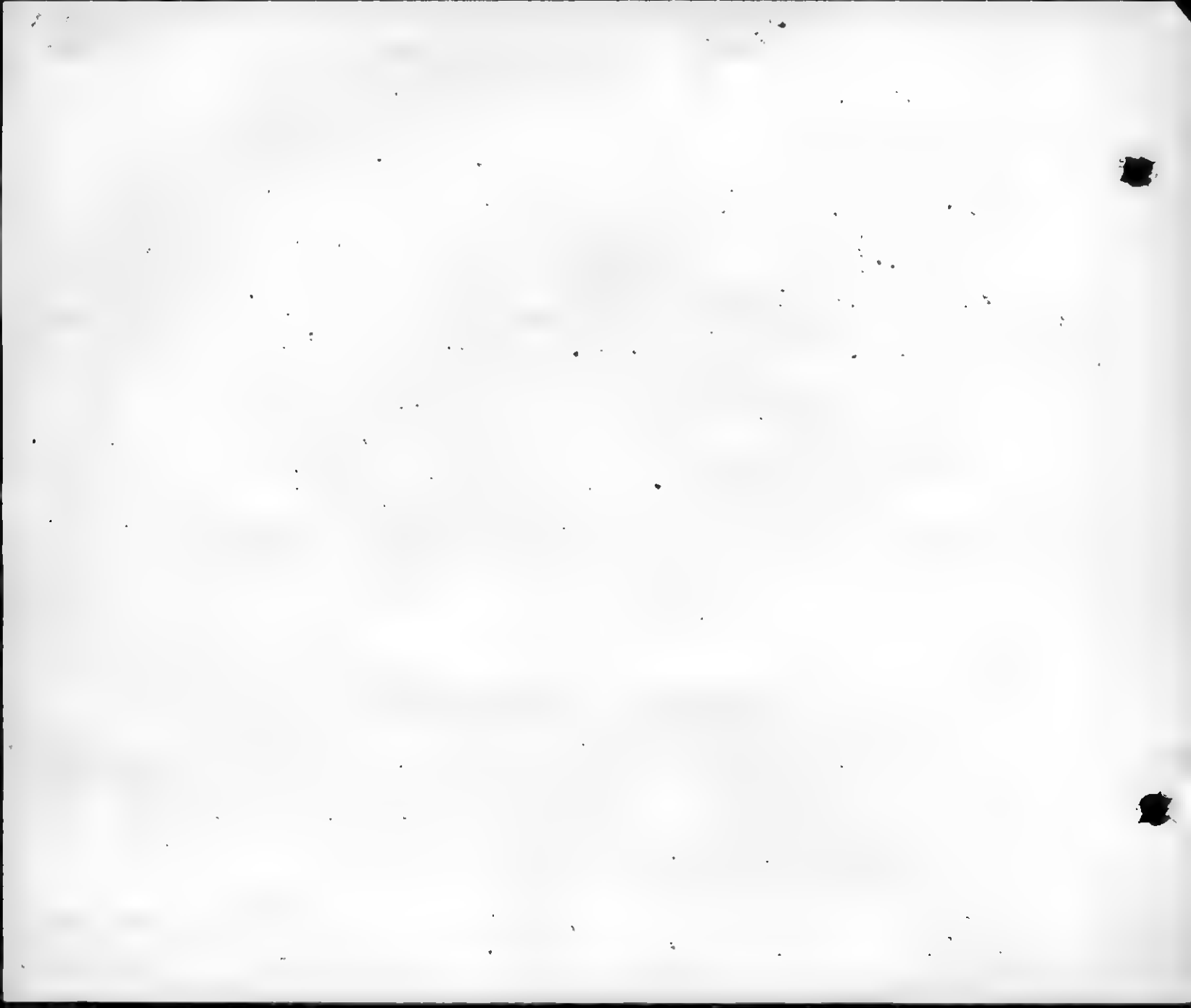
## 08810

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3431 Flannery Lane</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3431 Flannery Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Hyman Kaplan</u> First Middle Last 4. DATE OF DEATH <u>Aug 5, 1959</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 1, 1912</u> 9. AGE (In years last birthday) <u>47</u> yrs.				IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u> 11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Morris Kaplan</u> 14. MOTHER'S MAIDEN NAME <u>Bruna</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Mrs Edith Kaplan - Same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>arteriosclerosis C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>April 2, 1955</u> to <u>Aug 5, 1959</u> that I last saw the deceased alive on <u>Aug 5, 1959</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Manuel Levin</u> M.D. ADDRESS <u>4815 Reisterstown Rd</u> DATE SIGNED <u>5/5/59</u> PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u> <u>Balto-15 Ma</u>									
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/6/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Both Telford</u> 22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John Benson &amp; Sons Inc</u> ADDRESS <u>1120-26 W. North Ave</u> 24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>409 E. Penna. Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Olivia</u> Last <u>Kesting</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Towson Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emmie Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Queen E. Taylor - 4650 Railroad Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause, but one for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Broncho</u> DUE TO <u>Cerebral Thrombosis &amp; Left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-12-59</u> to <u>8-17-59</u> , that I last saw the deceased alive on <u>8-17-59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>19 W. Seminary Ave., Lutherville, Md.</u> DATE SIGNED <u>8/17/59</u> ACTUAL SIGNATURE <u>Bennett A. Stoen</u> PHYSICIAN'S NAME (Type) <u>Bennett A. Stoen, M. D.</u> <u>19 W. Seminary Ave., Lutherville, Md. 8/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Dr. Sullivan</u> ADDRESS <u>1014-137th St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arley S. House</u>	





## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8847

## CERTIFICATE OF DEATH

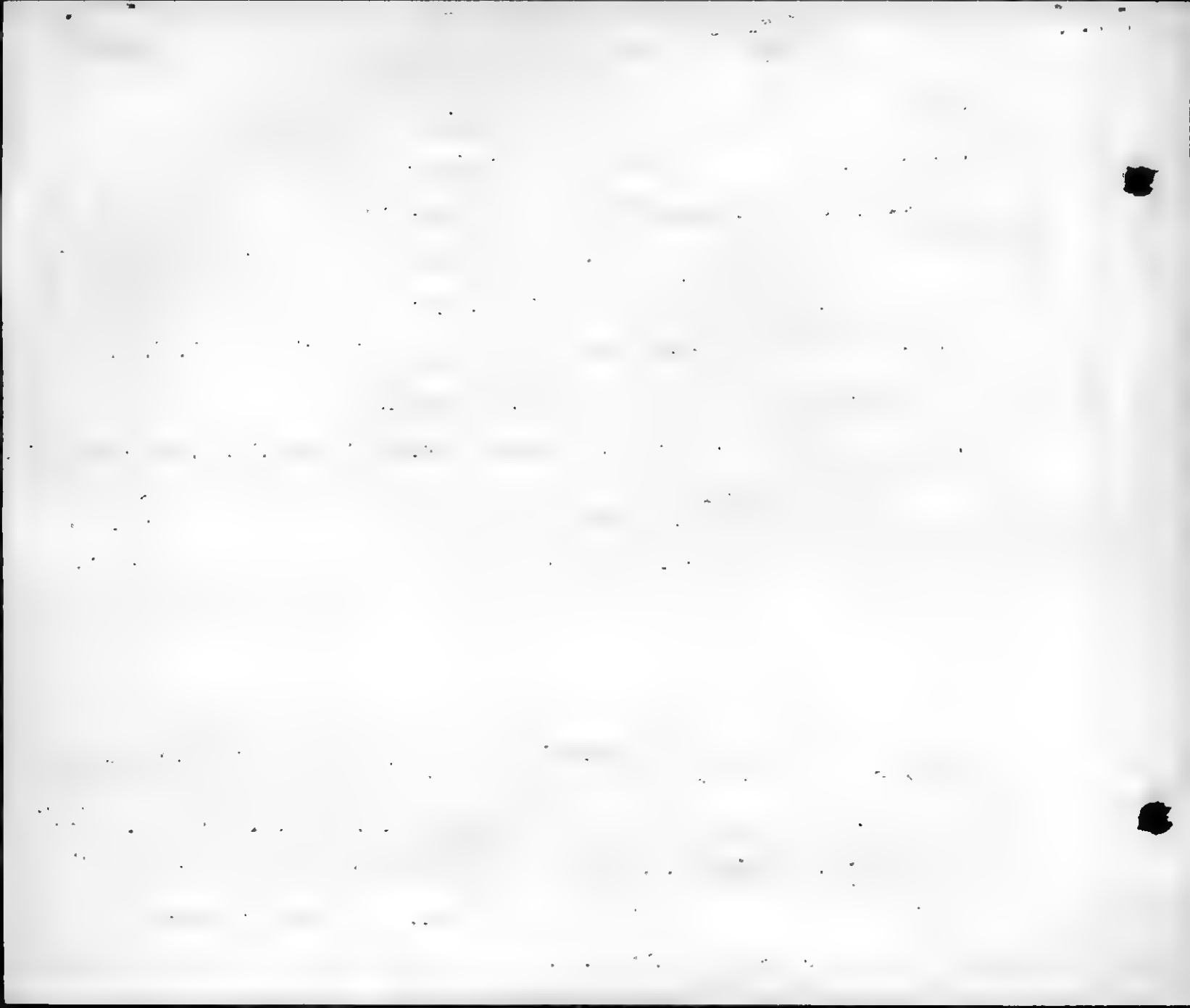
Reg. Dist. No.

08812

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>12 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>H.</b> Last <b>KIMBROUGH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1908</b>	9. AGE (In years last birthday) <b>51</b> yrs	IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Darby, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Kimbrough</b>				14. MOTHER'S MAIDEN NAME <b>Addie Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 225-18-2044</b>		INFORMANT Address <b>Clinical Records, V.A.H., Balto. 18, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>4/15X</b> DUE TO <b>NEPHROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>M</b> DUE TO <b>MALIGNANT HYPERTENSION</b> (c) <b>UNKNOWN</b> <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>August 13, 1959</b> to <b>August 25, 1959</b> , that he died on the <b>25th</b> day of <b>August</b> , 1959, at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) <b>VAH, BALTO, MD. FORT HOWARD DIVISION</b>					
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>8/26/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <input checked="" type="checkbox"/>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy Wilson, 1000 Brantley St. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Thomas</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8848

## CERTIFICATE OF DEATH

08813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>L.</u> Last <u>Kinard</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7/1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver F. Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Grove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-038202</u>		17. INFORMANT <u>Mr. Paul Hoffacker, Md. Line, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> ot work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>59</u> , to <u>4 August</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 August</u> , 19 <u>59</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reginald B. Gemmill</u>				ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u>		DATE SIGNED <u>7 August 1959</u>	
PHYSICIAN'S NAME (Type) <u>REGINALD B. GEMMILL</u>				<u>Stewartstown, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Fortenstein</u>				ADDRESS <u>New Freedom Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



#### b. COUNTY

22

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☐

Day	Year
19	1959

IF UNDER 1 YEAR		IF UNDER 24 HRS	
Months	Days	Hours	Min.

12. CITIZEN OF WHAT COUNTRY

Dorothea Stengel

Address

Records: SPRING CROVE STATE HOSPITAL

INTERVAL BETWEEN  
ONSET AND DEATH

### Generalized arteriosclerosis

19 WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.)

(State)

DATE SIGNED \_\_\_\_\_

8-20-59

Catonsville 28. Larry and

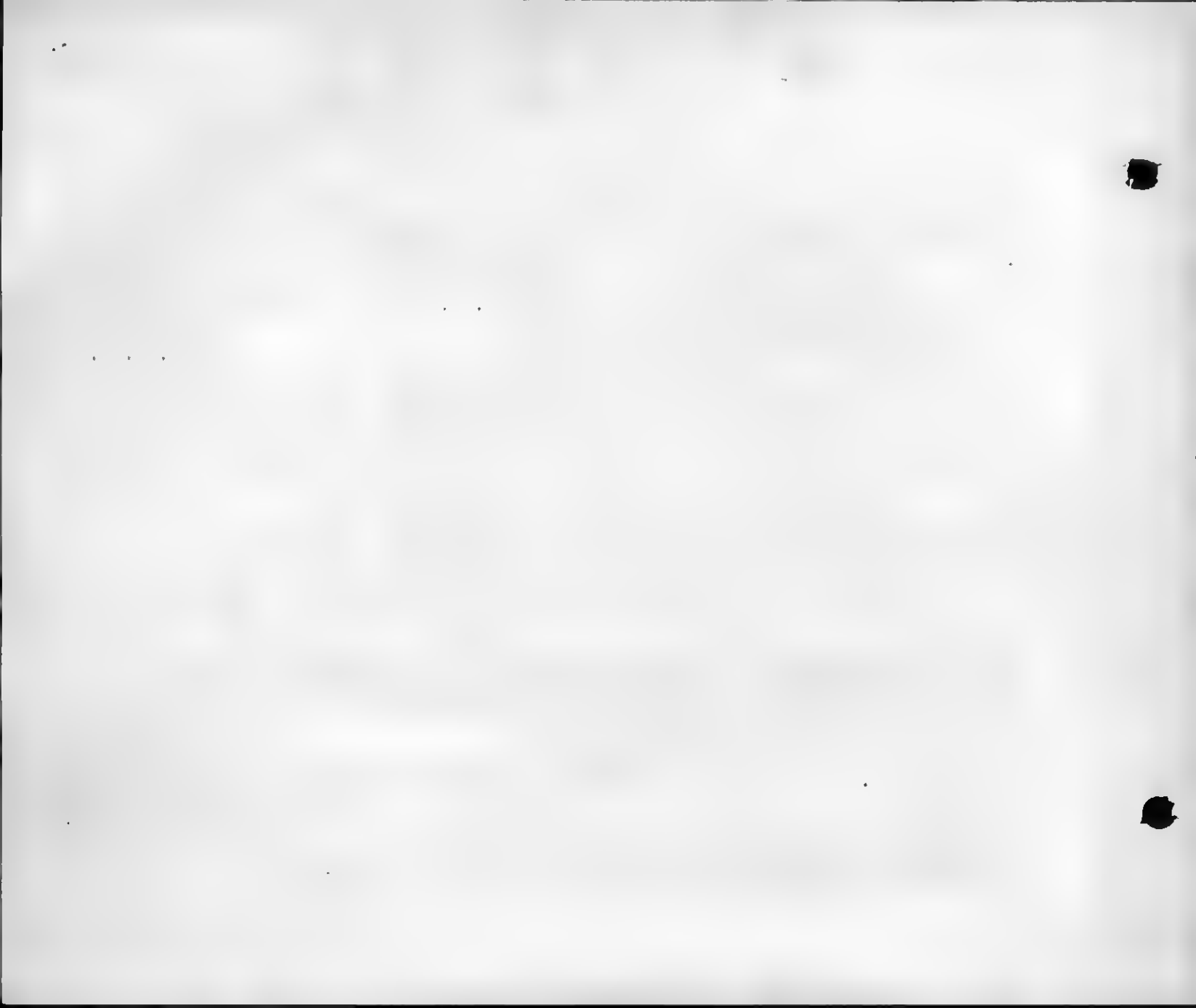


24b. REGISTRAR'S SIGNATURE \_\_\_\_\_

DATE AUG 21 '59

Arthur L. Frank

V\$ A15 (4)  
15M 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

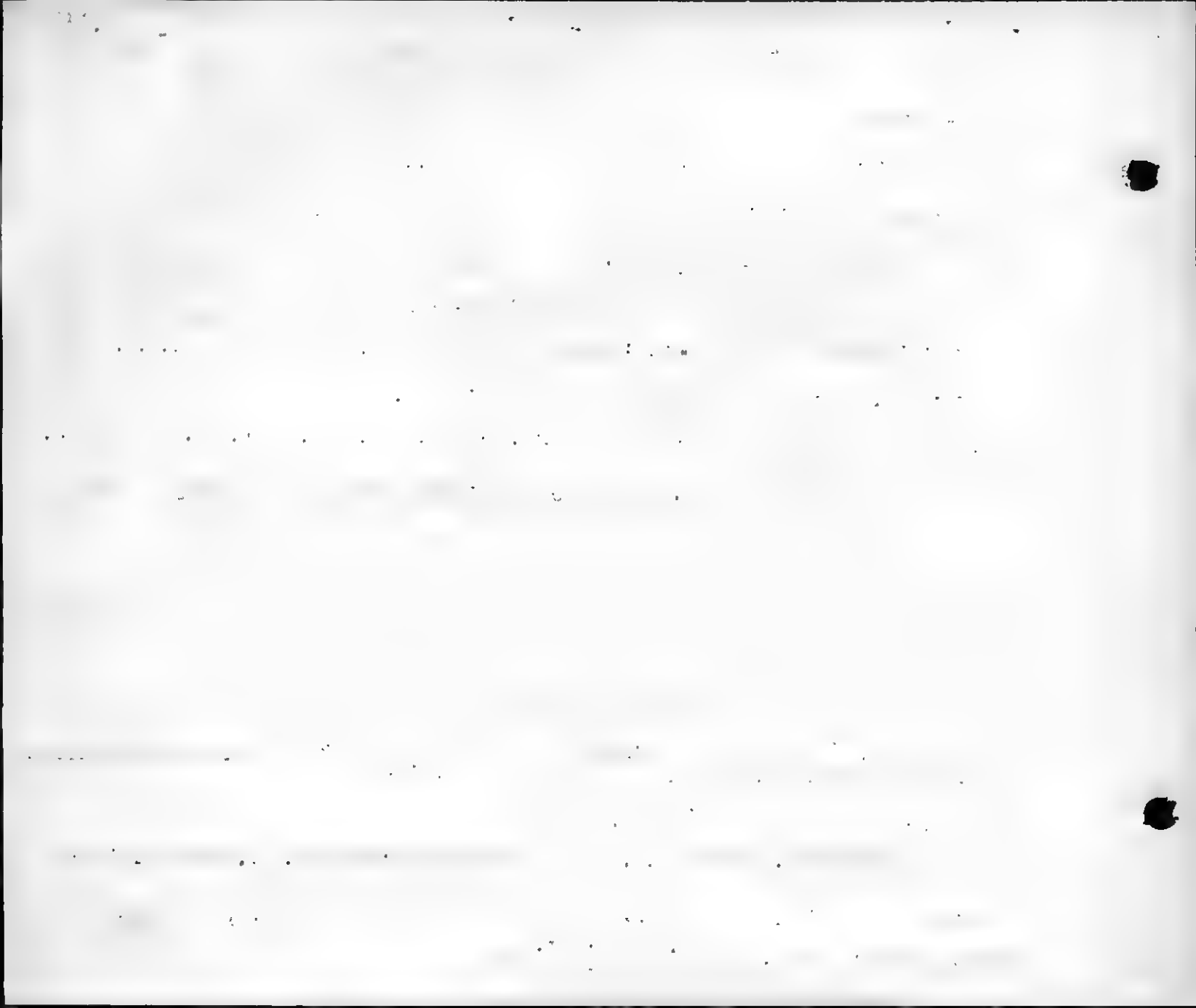
Reg. Dist. No.

08815

8850

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>S.</b> Last <b>KIRBY</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 24, 1893</b>	
9. AGE (In years lost birthday) <b>65 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>George B. Kirby</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Fredericks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>215-09-4354</b>		INFORMANT Address <b>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE STOMACH WITH CARCINOMATOSIS</b> <b>151X</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 8</b> , 19 <b>59</b> , to <b>August 29</b> , 19 <b>59</b> , and that death occurred at <b>9:55A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Lawrence D. Marcus</b> M.D.				PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b> <b>VAH, Baltimore, Md.-Ft. Howard Division</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Home, Baltimore 30, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8851

## CERTIFICATE OF DEATH

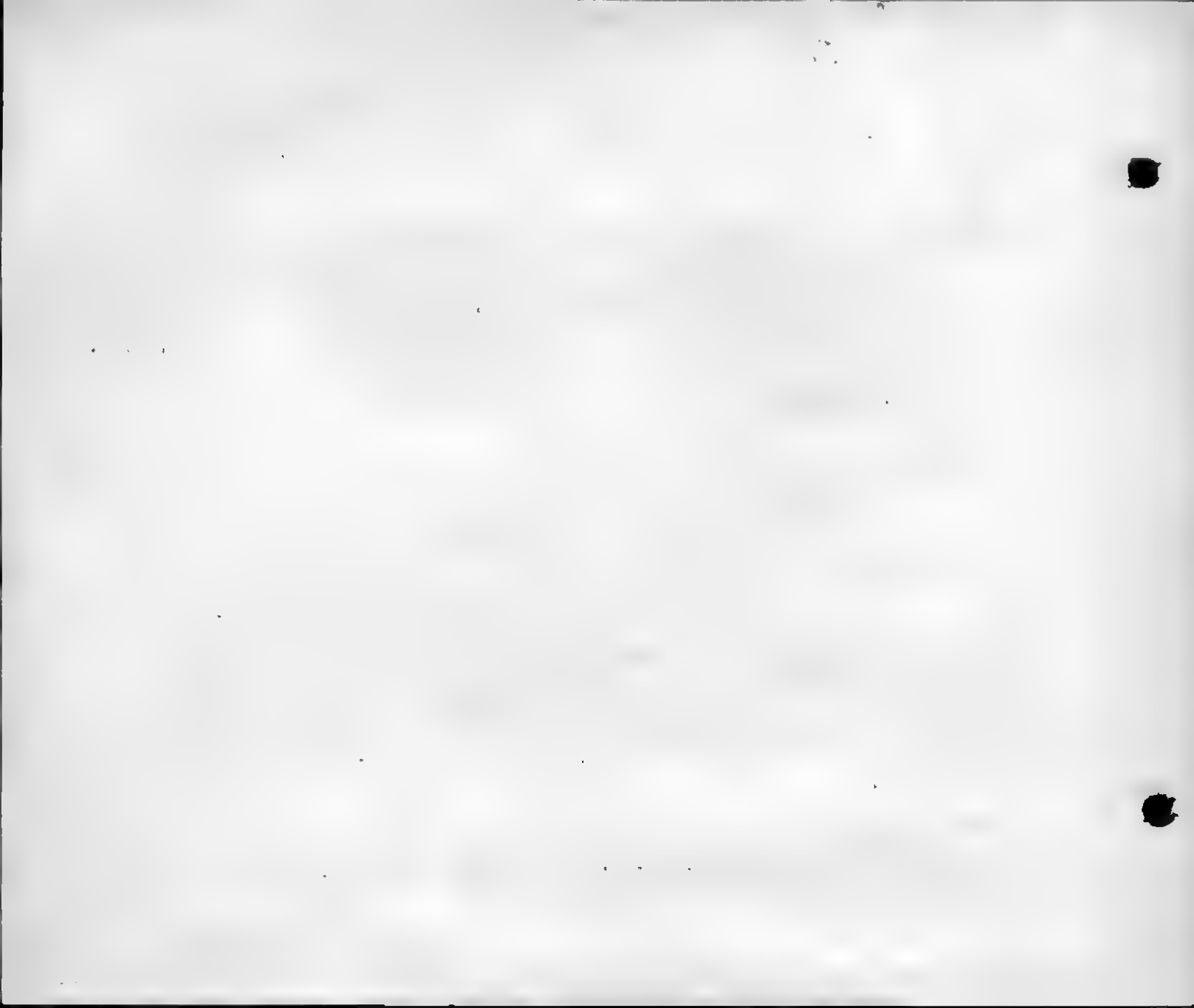
09956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>23yr9mth11days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>Edward</b> Middle <b>Klein</b> Last				4. DATE OF DEATH <b>August</b> Month <b>23</b> Day Year <b>59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1898</b>		9. AGE (In years last birthday) yrs <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Fred W. Klein</b>				14. MOTHER'S MAIDEN NAME <b>Ida Mariner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Address <b>Records; SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug. 14</b> , 19 <b>59</b> , to <b>Aug. 23</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug. 23</b> , 19 <b>59</b> , and that death occurred at <b>8:45a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachner</b>		M. D. <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED <b>9-1-59</b>			
PHYSICIAN'S NAME [Type] <b>Stella Wachner, M. D.</b>		<b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>	22b. DATE THEREOF <b>9/10/59</b>	22c. NAME OF CEMETERY OR CREMATION <b>U. of Md. Med. School</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <b>SEP 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kins</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



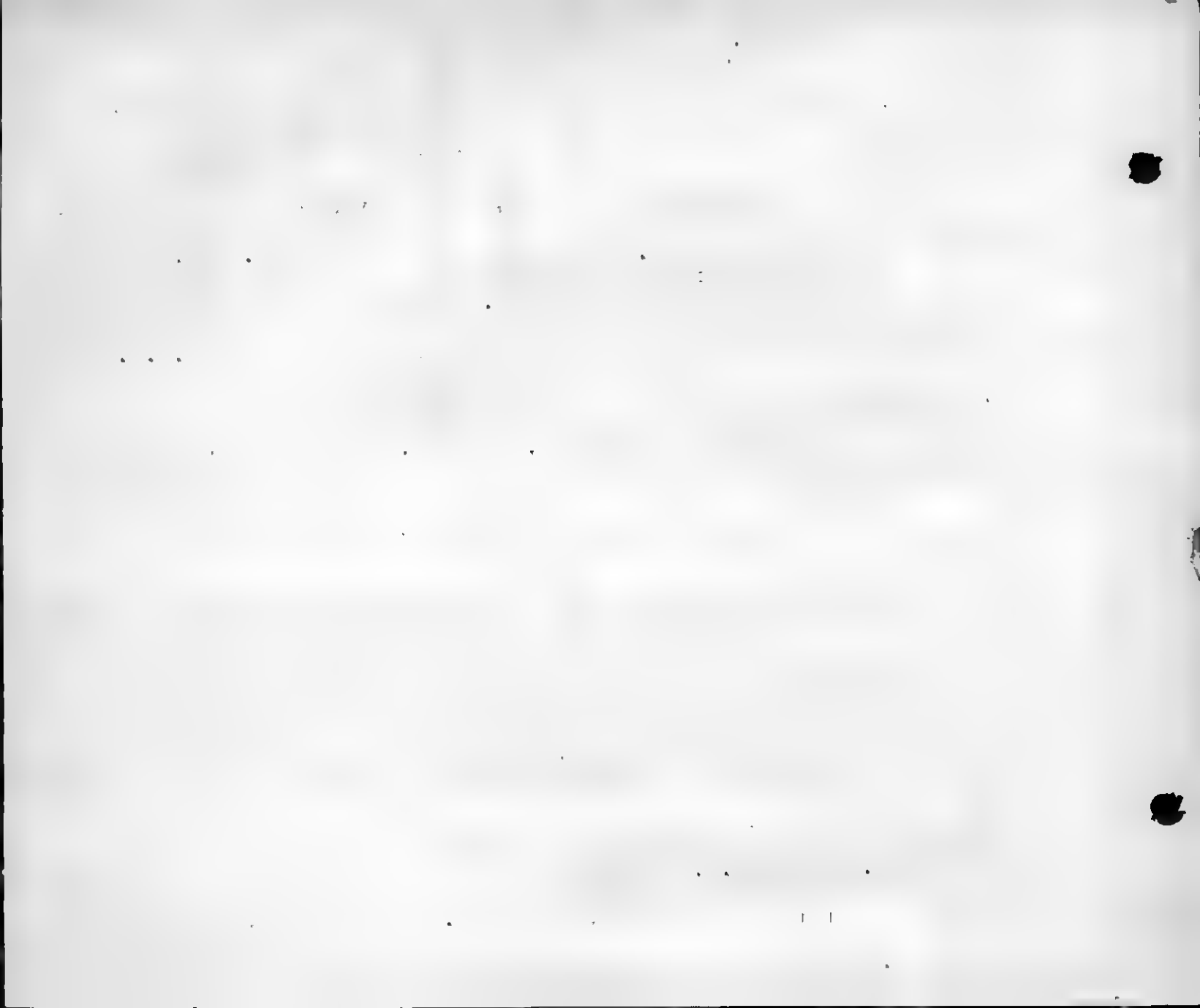
8763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4401 John Avenue</b>		e. STREET ADDRESS <b>4401 John Avenue</b>	
3. NAME OF DECEASED First <b>George</b> Middle <b>S.</b> Last <b>Knecht</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>29,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Knecht</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kaiser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>215 07 7681</b>	
17. INFORMANT <b>Mrs. Helen B. Knecht</b>		Address <b>4401 John Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 20, 1959</b> to <b>Aug 29, 1959</b> , that I last saw the deceased alive on <b>Aug 29, 1959</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b> DATE SIGNED <b>1010 Keckler</b>			
ACTUAL SIGNATURE <b>Dr. George S.M. Kieffer</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. George S.M. Kieffer</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9:25 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR <b>SEP 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

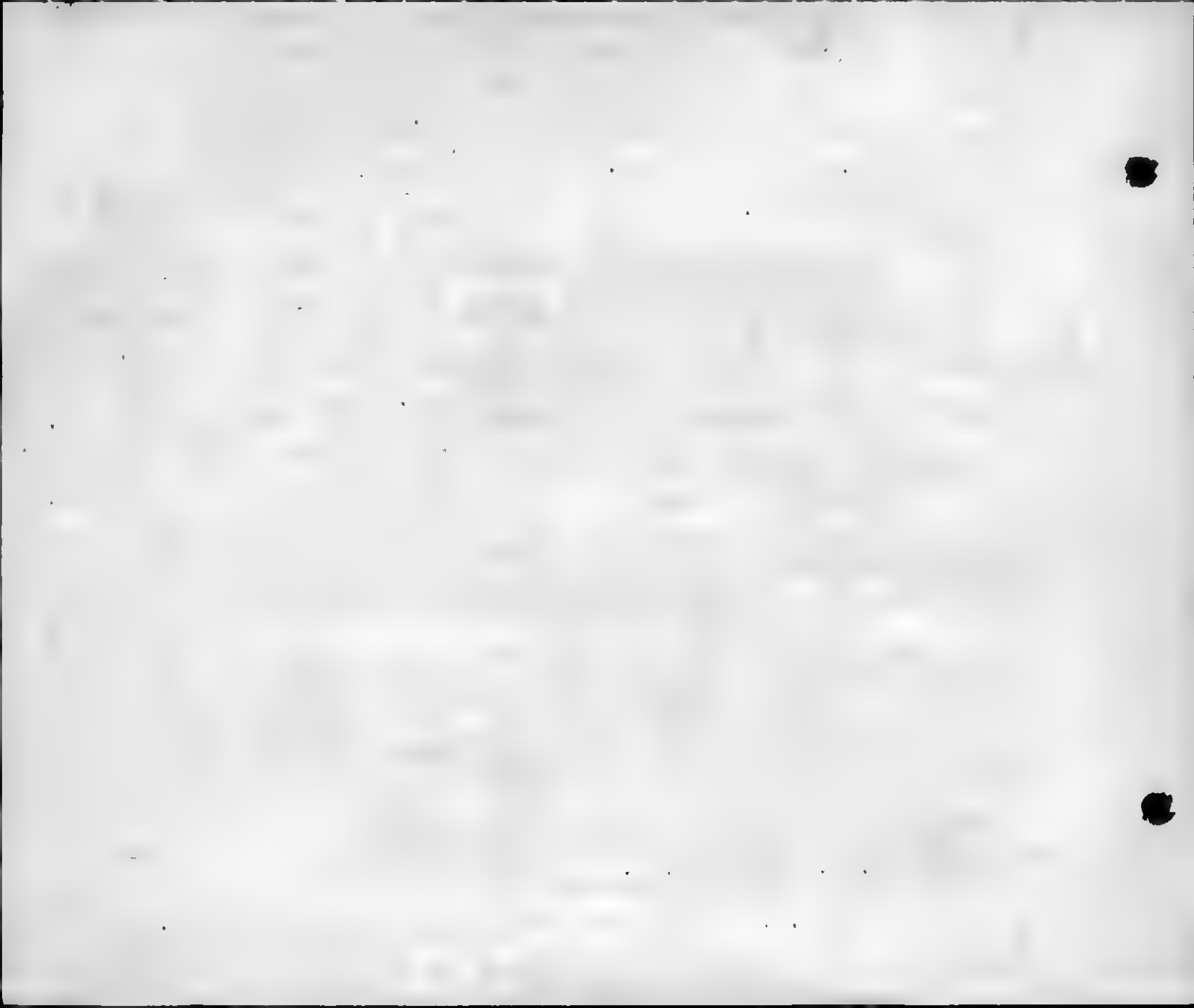
08817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>				c. LENGTH OF STAY IN 1b <u>4yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6719 Campfield Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>C.</u> Last <u>Kohlbauer</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Decemb 31, 1874</u>	
9. AGE (In years last b. today) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Parrish</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Weir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-32-9167</u>		17. INFORMANT <u>Ormond G. Cunningham, 6719 Campfield Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epilepsy</u> 3532 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <u>23 yrs.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>none</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>none</u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Parkville, Md.</u>				(State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>8, 11th St.</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate for the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



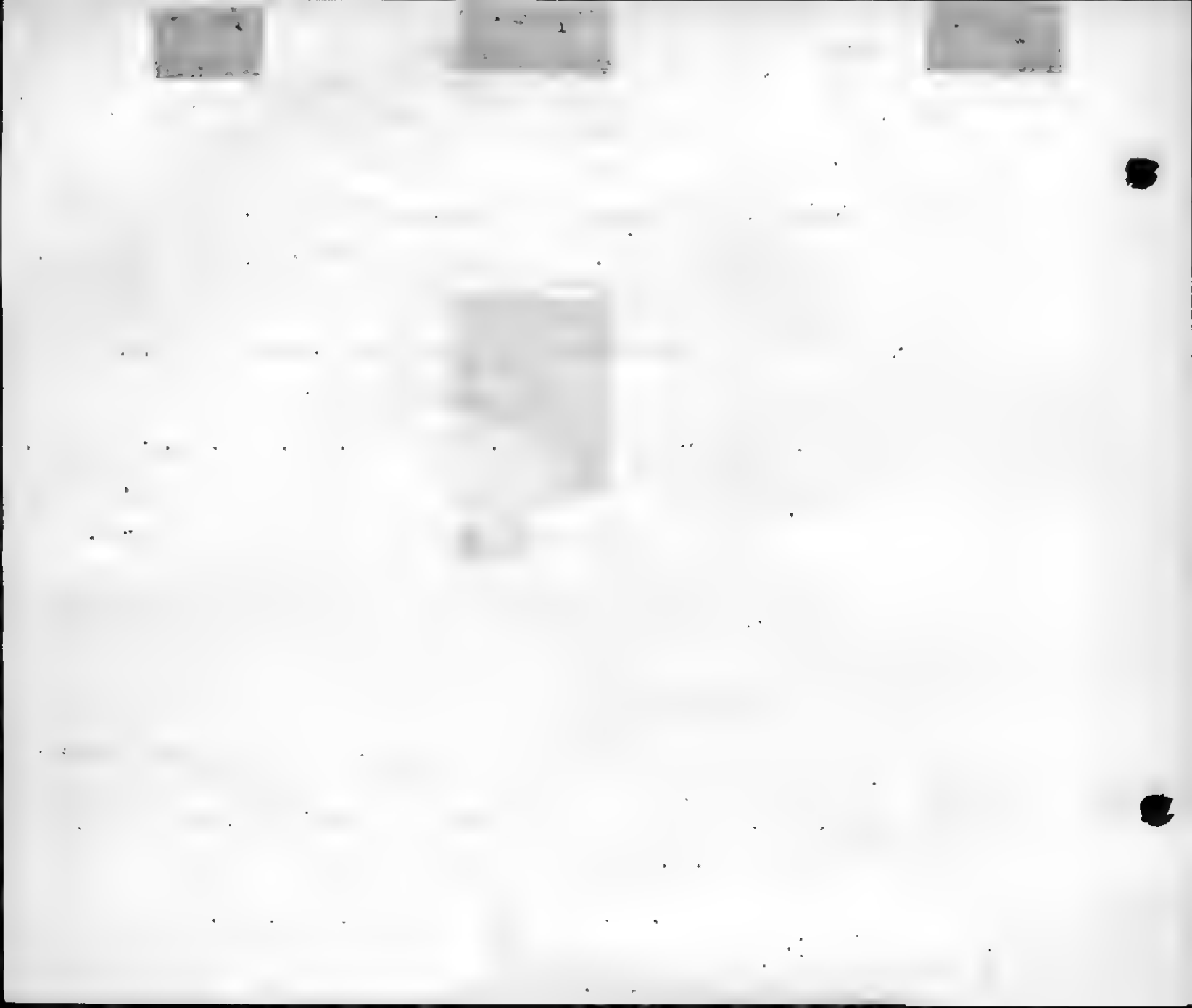
8853 Item 9 FilmG24-3-1-5-56 CERTIFICATE OF DEATH

Reg. Dist. No.

08818

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>L.</b> Last <b>KROL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 19, 1927</b>	
9. AGE (In years last birthday) <b>31 1/2</b> yrs.		10. AGE (In years last birthday) <b>31 1/2</b> yrs.		IF UNDER 1 YEAR Months <b>31</b> Days <b>12</b> Hours <b>00</b> Min. <b>00</b>		IF UNDER 24 HRS Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction(Houses)</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Peter Krol</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Ziemba</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>215-24-6915</b>			
17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b>							
200.1 <b>XXXXXX</b> ACUTE LYMPHATIC LEUKEMIA							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PYELONEPHRITIS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from <b>August 22, 1959</b> to <b>August 30, 1959</b> and that death occurred at <b>3:25 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles Allen</b>				ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M. D.</b>				DATE SIGNED <b>8/30/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-2-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bruzdzinski Funeral Home</b>				24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Carlton J. Krawa</b>				DATE <b>SEP 2 '59</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.





TO DEPUTY A. AL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give ages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

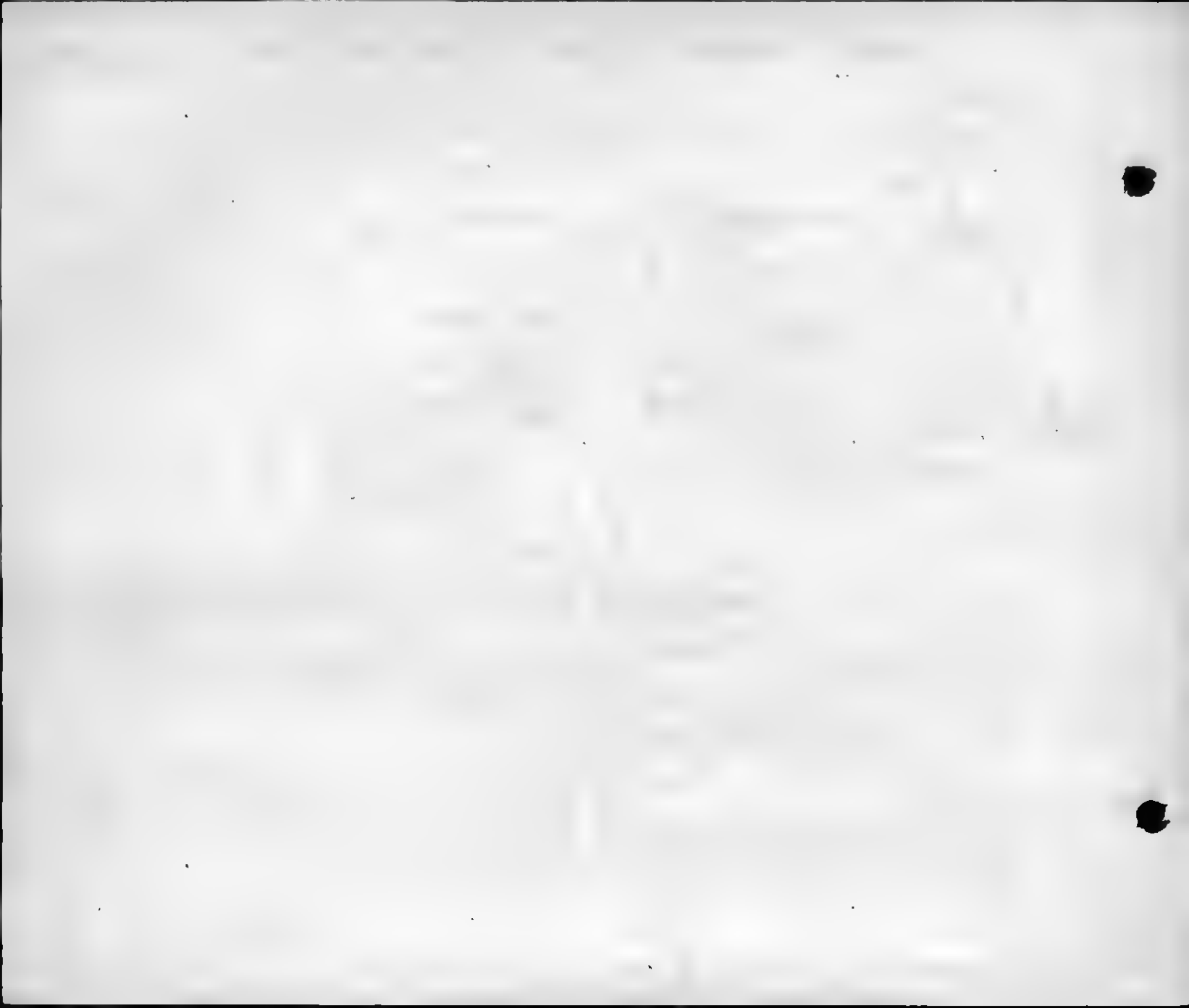
VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08819

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1737 STOKESLEY RD.</b>				d. STREET ADDRESS <b>1737 STOKESLEY RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J.</b> Last <b>LAMB DIN</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 23, 1918</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPYARD WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SPARROWS PT.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY LAMB DIN</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA FROHN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO. <b>313-05-5567</b>		17. INFORMANT <b>MRS. DOLORES LAMB DIN</b> Address <b>1737 STOKESLEY RD. (22) MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M. B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George W. Hoffmann</b>				ADDRESS <b>3218 HUDSON ST.</b>		24a. REC'D BY REGISTRAR <b>AUG 19 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. H. S. K...</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08820

Reg. Dist. No.

8759

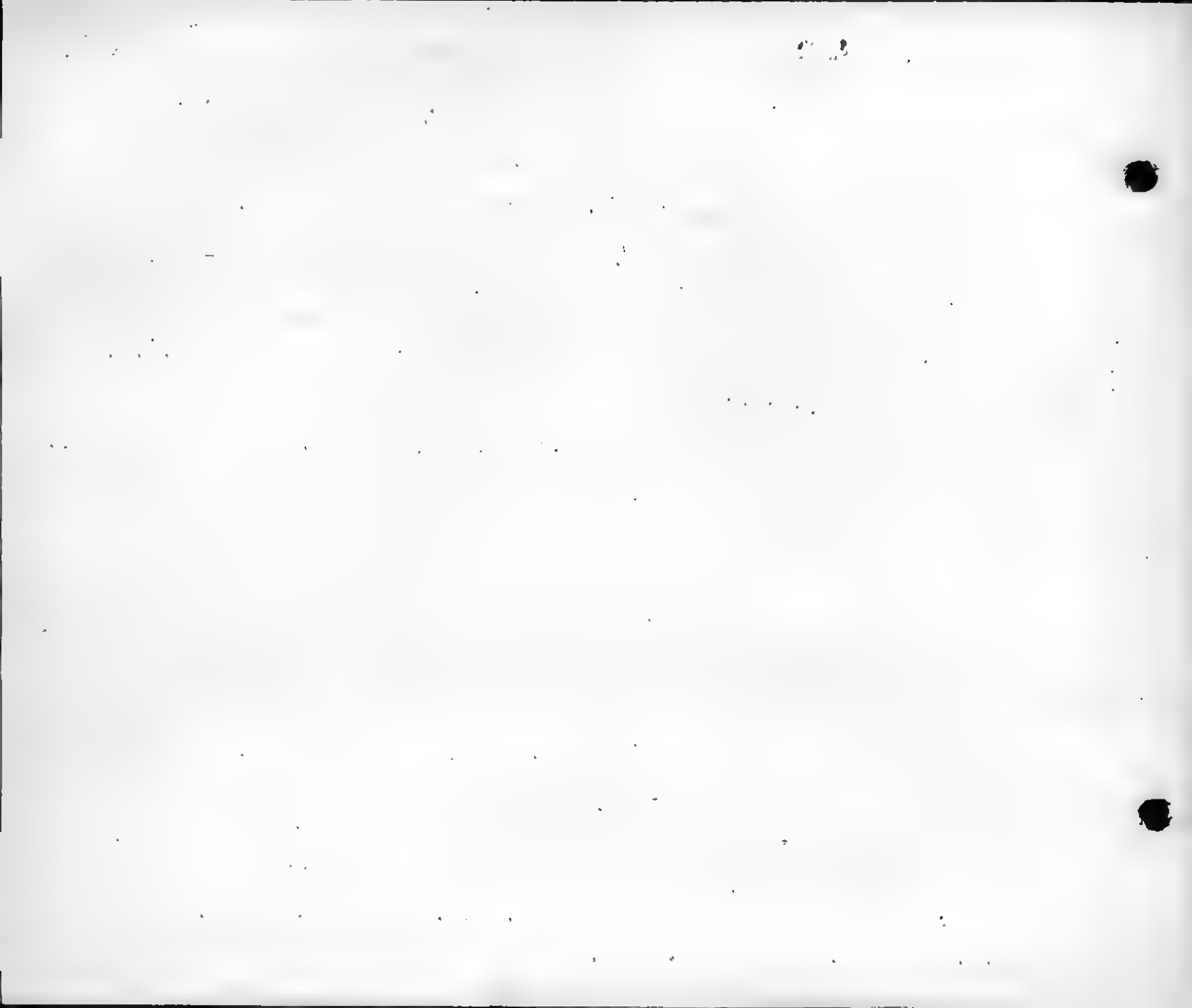
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7524 Rabon Avenue</b>				d. STREET ADDRESS <b>7524 Rabon Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BONITA</b> Middle <b>LOUISE</b> Last <b>LARRIMORE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1958</b>	
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>35</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel Larrimore</b>				14. MOTHER'S MAIDEN NAME <b>Yvonne Fetterhoff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Daniel Larrimore, 7524 Rabon Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital heart disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVA. BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b> EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>8/25/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Road</b>				24a. REC'D BY REGISTRAR <b>AUG 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8510 Chestnut Oak Rd.</i>		d. STREET ADDRESS <i>8510 Chestnut Oak Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Anita</i> Middle <i>J.</i> Last <i>Linder</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>24</i> - Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2, 1884</i>
9. AGE (In years lost birthday) yrs. <i>75</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Paul C. Gonnissen</i>		14. MOTHER'S MAIDEN NAME <i>Marie Pruss</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <i>Marie Merryman 8510 Chestnut Oak Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> <i>331X</i> DUE TO (b) <i>Heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>2 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Tuberculosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 11, 1959</i> to <i>Aug 24, 1959</i> that I last saw the deceased alive on <i>Aug 24, 1959</i> and that death occurred at <i>4:30</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Robert L. ...</i>		DATE SIGNED <i>8/24/59</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Robert L. ...</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/28/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Monkton Meth. Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Monkton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>L.J. Ruck, Inc. 5305 Harford Rd. # 14</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 27 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



# STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18 8853 Item 7 Filed 8-13-59 et CERTIFICATE OF DEATH

08823

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>14 PRESTON STREET 2</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>SPAULDING EDWARD LOCKARD</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>8-5-1959</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-11-97</u>
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>PHILLIP LOCKARD</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY HOGARTY</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>NO.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-05-8698</u>	
<b>17. INFORMANT</b> Address <u>Hospital Records, Mt. Wilson State Hospital</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Larynx</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>2-18-</u> <u>1959</u> <b>to</b> <u>8-5-</u> <u>1959</u> , <b>that I last saw the deceased alive on</b> <u>8-4-</u> <u>1959</u> , <b>and that death occurred at</b> <u>4:40 AM</u> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <u>Mt. Wilson, Maryland</u> <b>DATE SIGNED</b> <u>8-5-59</u> <b>ACTUAL SIGNATURE</b> <u>William Newcomer</u> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <u>William Newcomer, M.D.</u> <u>Superintendent</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>8-10-59</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Charles Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Pikesville</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Frank H. Howell</u> <u>Pikesville Md</u>		<b>24. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Aug 10 1959</u> <u>Arthur S. House</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





1  
TO HOSPITAL OR FUNERAL DIRECTOR: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

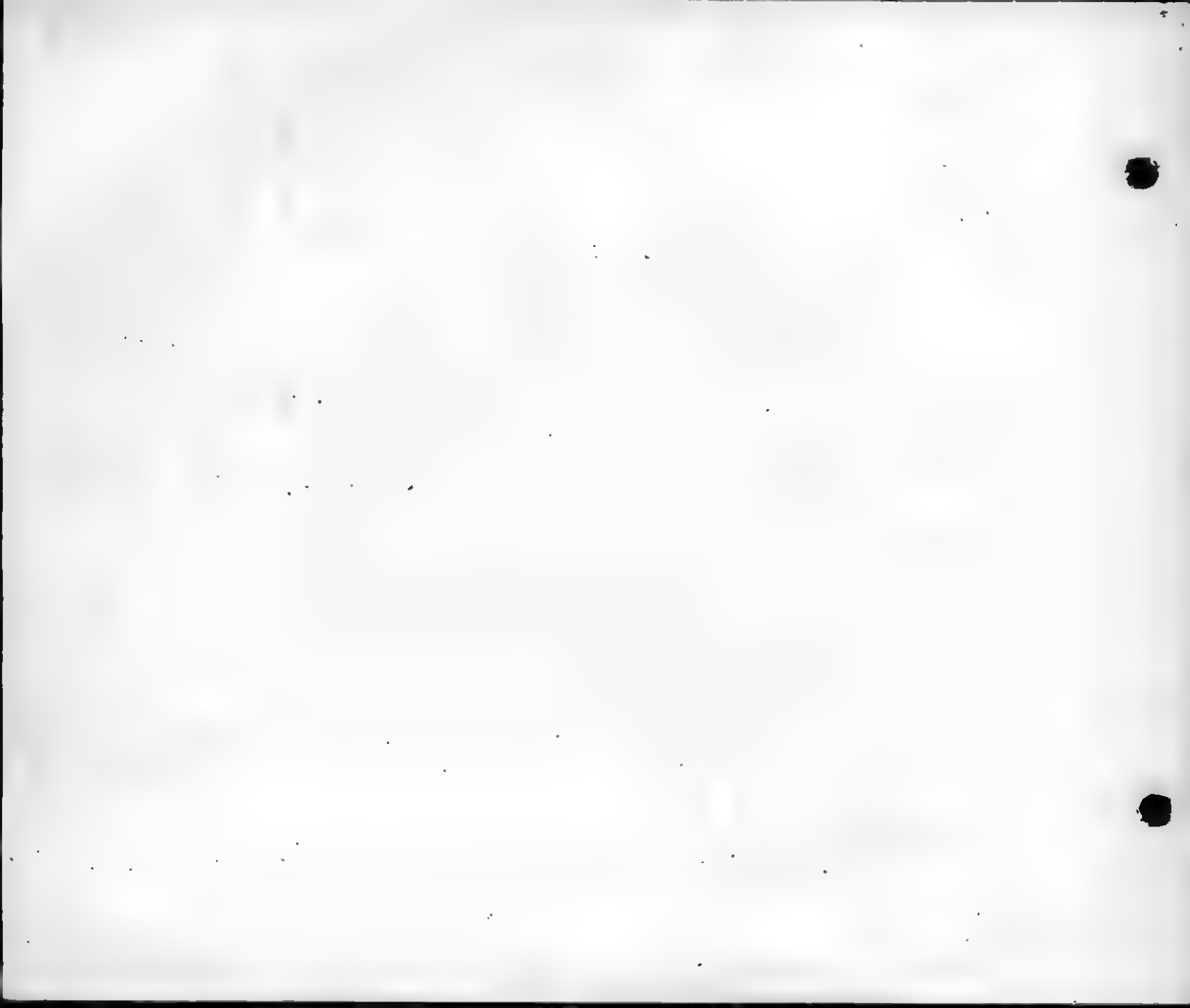
8856

## CERTIFICATE OF DEATH

Reg. Dist. No.

05824

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>4 YRS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1004 KENT AVE</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1004 KENT AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>BLANCHE</u> Last <u>Longan</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 16, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cluthing Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Christian C. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>DORA MARTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-67-6940</u>	
17. INFORMANT <u>Evelyn Brady</u>		Address <u>1004 KENT AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Disease Arteriosclerotic</u> DUE TO (b) <u>4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>epi</u> INTERVAL BETWEEN ONSET AND DEATH <u>epi</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/31, 1950</u> to <u>8/28, 1959</u> that I last saw the deceased alive on <u>8/28, 1959</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>651 N. Bentall St Baltimore Md</u> DATE SIGNED <u>SEP 1 1959</u>			
ACTUAL SIGNATURE <u>G. Mendel</u> M.D.		PHYSICIAN'S NAME (Type) <u>G. T. Mendelis</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-31-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo L. Schwab</u> ADDRESS <u>2101 Frederick Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 1 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>John E. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08825

8760

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1240 Circle Drive</b>		d. STREET ADDRESS <b>1240 Circle Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VELMA</b> Middle <b>JACOBS</b> Last <b>LYNCH</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>27,</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1906</b>
9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John George Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Catherine Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes World War II</b>		16. SOCIAL SECURITY NO. <b>213-28-8000</b>	
17. INFORMANT <b>Mr. Edmond J. Lynch - 1240 Circle Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with Widespread Metastases</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 21, 1959</b> to <b>August 27, 1959</b> , that I last saw the deceased alive on <b>August 25, 1959</b> , and that death occurred at <b>6:00 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Arthur Rossberg M.D.</b>		ADDRESS (Street, city or town, state) <b>2436 Washington Blvd. Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. ARTHUR ROSSBERG M.D.</b>		DATE SIGNED <b>Aug 31 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Rossberg - Balt MD</b>		24a. REC'D BY REGISTRAR <b>Aug 31 59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Rossberg</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

8857

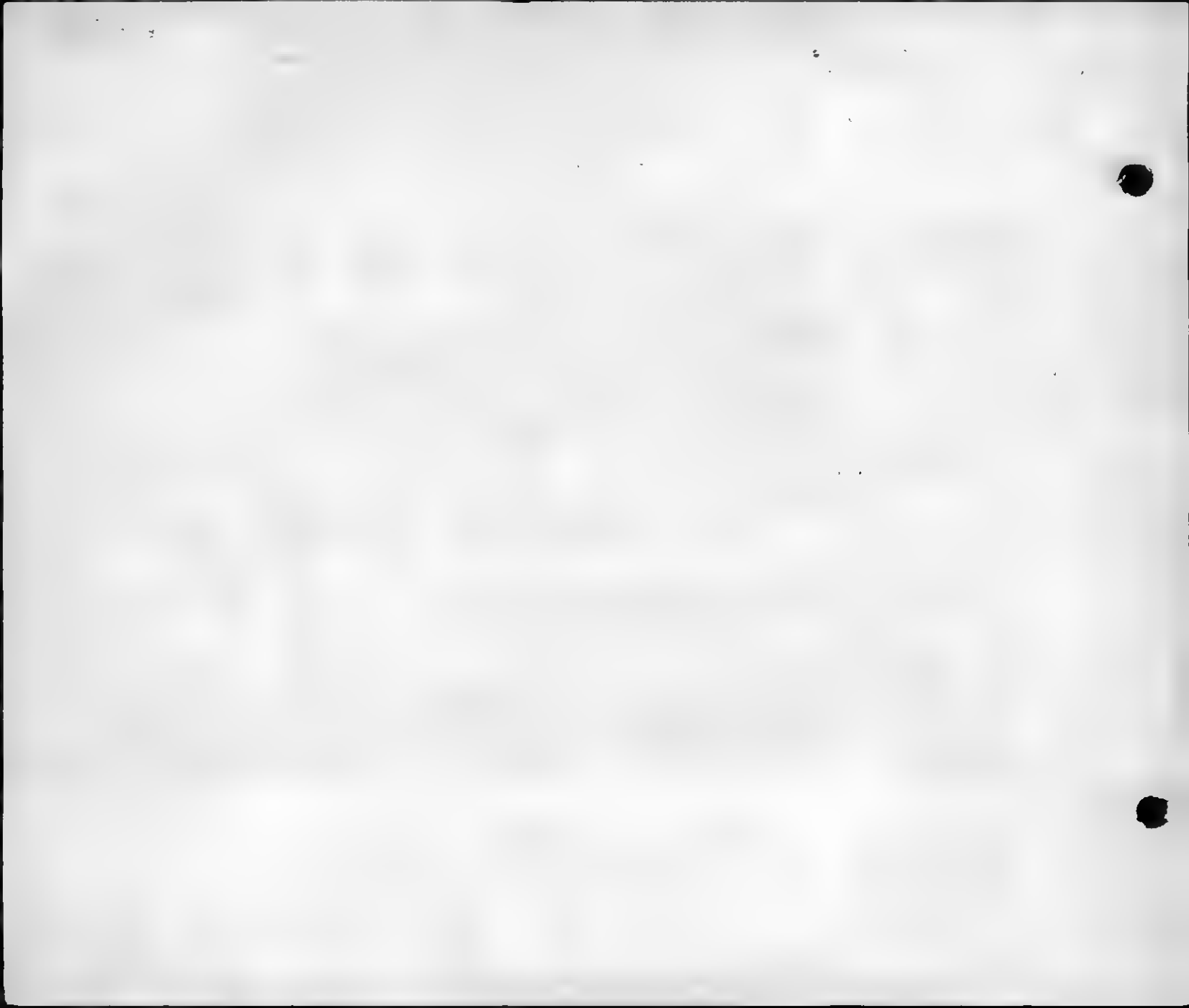
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>		c. LENGTH OF STAY IN 1b <u>6 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>253 ADDICHS FARM RD</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>	
3. NAME OF DECEASED (Type or print) <u>FAMILY STEWART MACKLIN</u>		f. STREET ADDRESS <u>253 ADDICHS FARM RD</u>	
4. DATE OF DEATH Month <u>AUG</u> Day <u>15</u> Year <u>1957</u>		5. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>IV</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-72</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>15</u> Hours <u>19</u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM A STEWART</u>		14. MOTHER'S MAIDEN NAME <u>SLAUGHTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>FAMILY STEWART CROSS 253 ADDICHS FARM RD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN</u>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>			
DUE TO (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pollock</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A. POLLOCK</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co. 4905 York Road</u>		24. REC'D BY REGISTRAR <u>AUG 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION



06827

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
\$64 2.57

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere - Baltimore - 19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2646 - Massachusetts Ave</u>		d. STREET ADDRESS <u>3916 - Foster Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Evering</u> Middle <u>Martell</u> Last		4. DATE OF DEATH <u>August - 11</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28 - 1905</u> 9. AGE (In years last birthday) <u>53</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Martell</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Heidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>213-09-088</u>	
17. INFORMANT <u>Sophia L. Martell</u>		Address <u>3916 - Foster Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Coarctation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		DATE SIGNED <u>8-13-59</u>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>		22b. DATE THEREOF <u>8/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Wolverton</u>		24a. REC'D BY REGISTRAR <u>Aug 14 '59</u>	
ADDRESS <u>Funeral Home 6306 - Belair Rd - Baltimore - 6 - Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u>	





8859

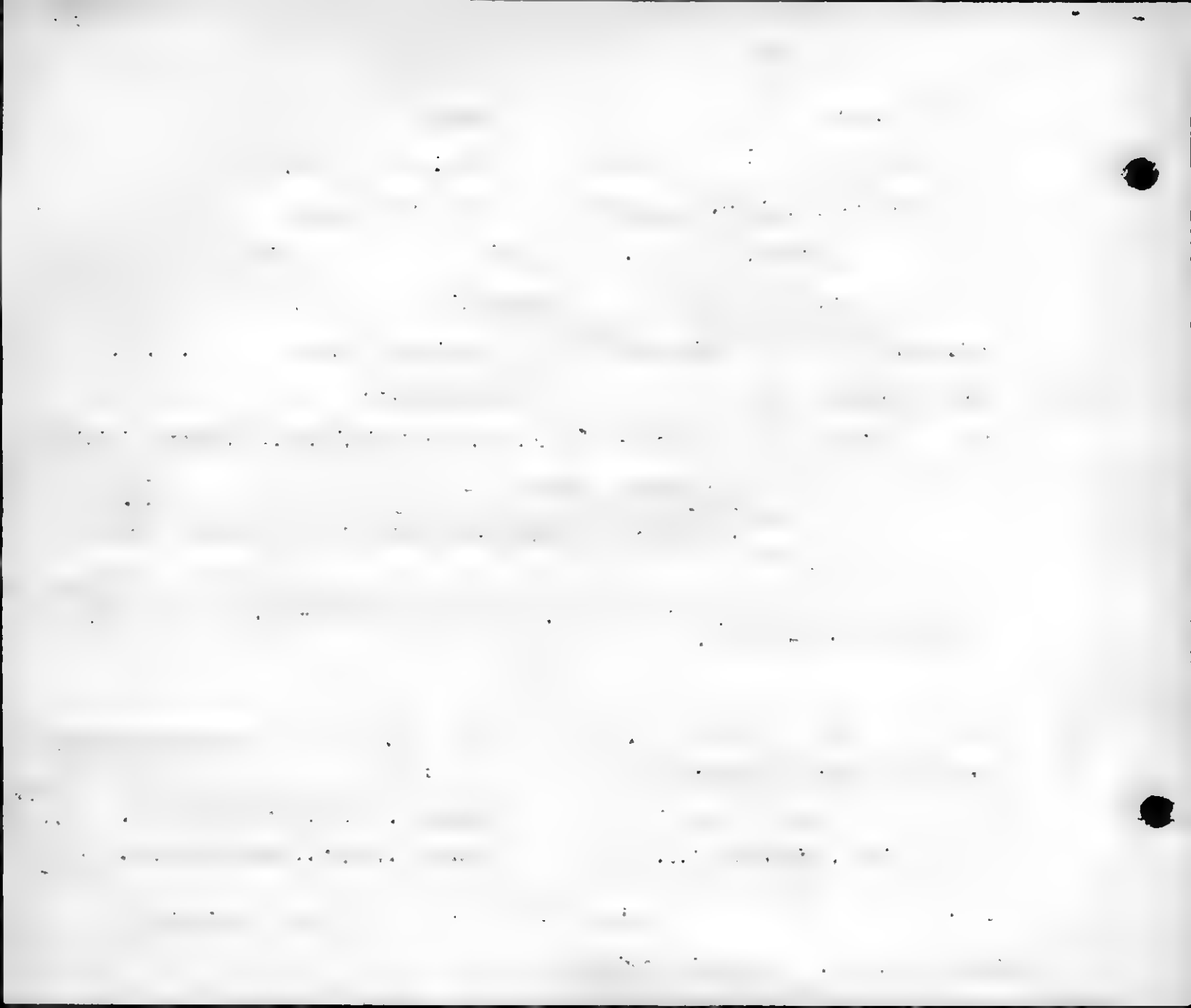
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>41 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(6)</b> d. STREET ADDRESS <b>4220 Kolb Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>F.</b> Last <b>MATTHEWS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1896</b>	
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		12. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Projectionist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Camera</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Conrad Matthews</b>			
14. MOTHER'S MAIDEN NAME <b>Amelia Carter</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md., Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA - OLD</b> <b>DEEP PULMONARY ABSCESS, LEFT LUNG - OLD</b> <b>METASTATIC CARCINOMA, MEDIASTINAL LYMPH NODES-OLD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>NO</b> (c) <b>NO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CORONARY ARTERIOSCLEROSIS, MARKED-OLD. MYOCARDIAL SCARRING-OLD. PULMONARY EDEMA - RECENT.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14</b> , 19 <b>59</b> , to <b>August 26</b> , 19 <b>59</b> , that I last saw the deceased <b>3:15 P.M.</b> from the causes and on the date stated above <b>VAH, BALTO., 18, MD, FORT HOWARD DIV.</b>							
ACTUAL SIGNATURE <b>John W. Crawford</b>				DATE SIGNED <b>8/27/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				DATE <b>8/27/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Bros., Inc.</b>				24. REC'D BY REGISTRAR <b>AUG 28 '59</b>			
ADDRESS <b>7110 Belair Road, Balto., Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8860

## CERTIFICATE OF DEATH

08829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2mth29dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Matulitus</b> Last <b>Matulitus</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 3, 1883</b>	9. AGE (In years last birthday) yrs <b>76</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>59</b>	IF UNDER 24 HRS Months <b>7</b> Days <b>19</b> Hours <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Lithuania</b> ✓	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>164-20-8043</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease with poss. infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8</b> , 19 <b>59</b> , to <b>August 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 7</b> , 19 <b>59</b> , and that death occurred at <b>9:30a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>8-7-59</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8/11/59</b>		<b>Cedar Hill Cemetery, Ritchie Hwy.</b>		<b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Ashburner</b>				ADDRESS <b>637 Wash Blvd</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 10 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles S. Knaus</b>	



8766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PELAI</u>				c. LENGTH OF STAY IN 1b <u>7 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5005 HAZEL AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>J</u> Last <u>McMAMMIS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD COTTON</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>PATRICK J. McMAMMIS</u>				14. MOTHER'S MAIDEN NAME <u>MARIA C. KEEFE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>24-65 8447</u>			
17. INFORMANT <u>ANNIE McMAMMIS</u>				Address <u>5005 HAZEL AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) <u>Chronic Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Arthritis Severe</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>  </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>59</u> , to <u>8/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1305 Franklin Ave. 8/31/59</u> ACTUAL SIGNATURE <u>J. N. Frederick MD</u> M.D. PHYSICIAN'S NAME (Type) <u>Balto. MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-2-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENVALE</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Howard Strong</u>				ADDRESS <u>320 TWENTY-FOUR AVE</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Orin L. Kraus</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8861

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STONELEIGH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STONELEIGH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>909 GREENLEIGH RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUD E. McMULLEN</b>		4. DATE OF DEATH Month Day Year <b>AUG. 31 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 21, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>N.H.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GATES W. HODGON</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN COLBATH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>JOHN G. McMULLEN</b> Address <b>SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>155.1</b> IMMEDIATE CAUSE (a) <b>CARCINOMA, gall bladder</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 19 57</b> to <b>31 Aug 19 59</b> , that I last saw the deceased alive on <b>30 Aug 19 59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. De Hoff</b> M.D.		ADDRESS (Street, city or town, state) <b>Loch Raven Shop. Co.</b> DATE SIGNED <b>Balto 12 -</b>	
PHYSICIAN'S NAME (Type) <b>JOHN B. DE HOFF</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FARMINGTON</b>	22d. LOCATION (City, town, or county) (State) <b>FARMINGTON N.H.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. JENKINS &amp; SONS CO.</b> ADDRESS <b>4905 YORK RD.</b>		24a. REC'D BY REGISTRAR <b>SEP 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Archib &amp; Hines</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8862

## CERTIFICATE OF DEATH

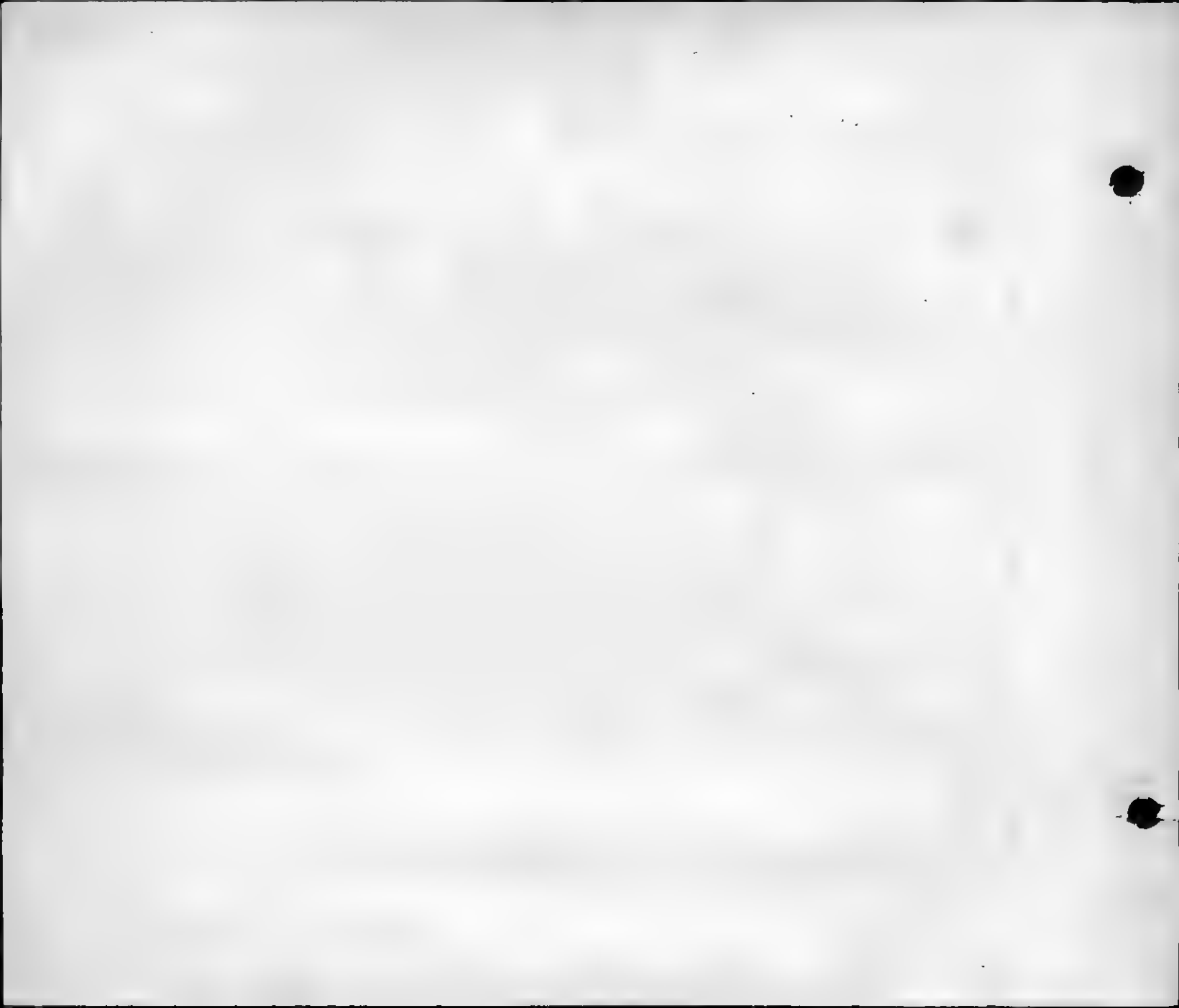
00832

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At-Home</b>		e. STREET ADDRESS <b>617 Dorsey Ave</b>	
3. NAME OF DECEASED (Type or print) <b>CORA V. MERRIKEN</b>		4. DATE OF DEATH <b>Aug 7 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ELLINGSWORTH</b>		14. MOTHER'S MAIDEN NAME <b>ADAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>HARRY MERRIKEN</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior Septal Heart Infarction</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1957</b> to <b>Aug 7 1959</b> , that I last saw the deceased alive on <b>Aug 7 1959</b> , and that death occurred at <b>10:30 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.		ADDRESS (Street, city or town, state) <b>815 E. 15 Ave</b>	
DATE SIGNED <b>9/9/59</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN, M.D. Balt. 21 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN Cem</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Connelly</b>		ADDRESS <b>418 Eastern Blvd. (2)</b>	
24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. Page 4  
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08833

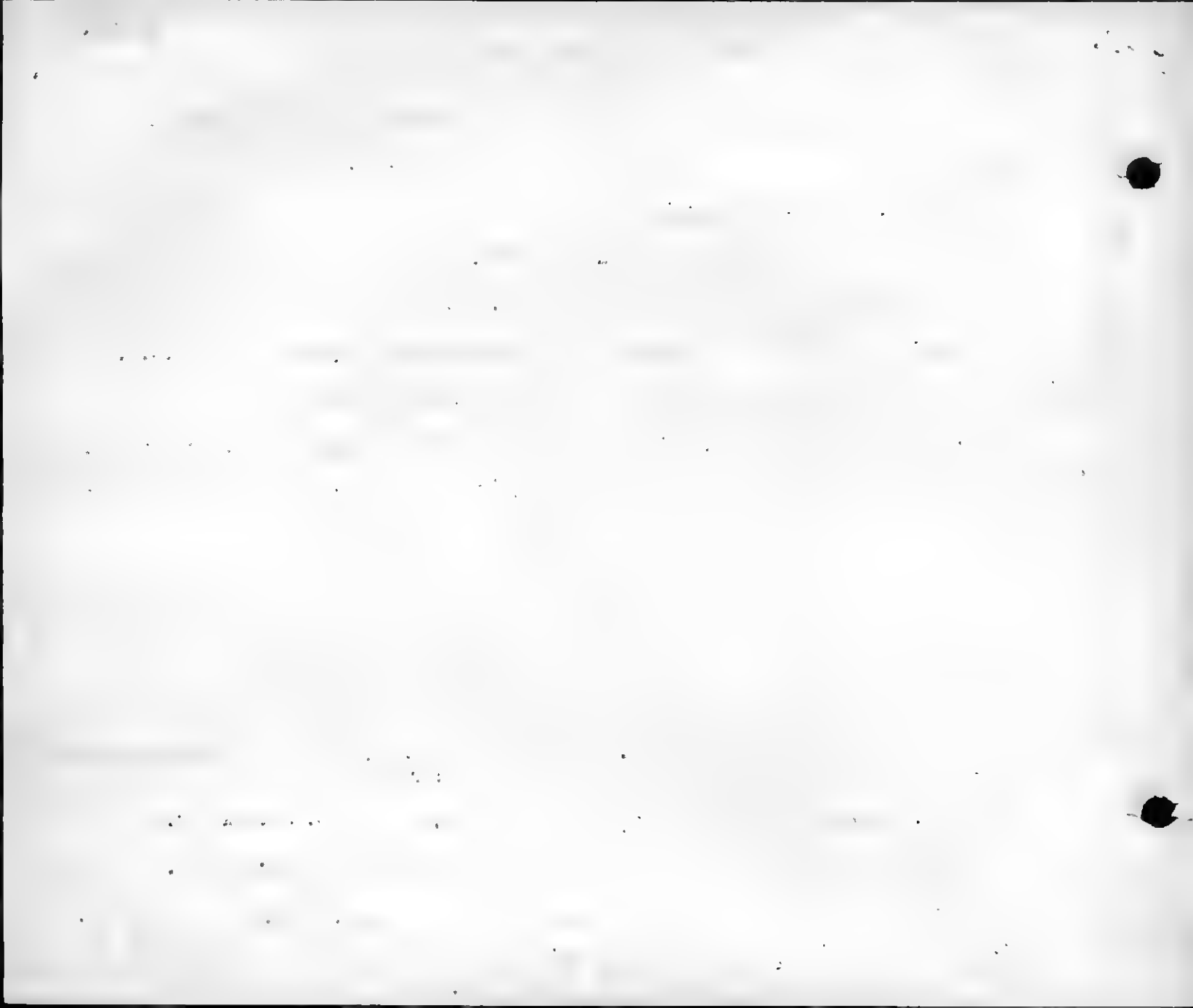
8863

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>E.</b> Last <b>MERRYMAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 28, 1919</b>
9. AGE (in years last birthday) <b>39</b>		IF UNDER 1 YEAR <b>39</b> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11 BIRTHPLACE (State or foreign country) <b>Hampstead, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Merryman</b>		14. MOTHER'S MAIDEN NAME <b>Ida A. Biles</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>220 07 7700</b>	
INFORMANT <b>Clin. Records VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC GLOMERULONEPHRITIS WITH UREMIA</b> DUE TO (b) <b>592X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Unknown</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>August 7</b> , 19 <b>59</b> , to <b>August 9</b> , 19 <b>59</b> , that <b>VA</b> was the deceased's physician, and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Conrad E. Grodzky</b> M.D.		ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Md.</b> DATE SIGNED <b>8/9/59</b>	
PHYSICIAN'S NAME (Type) <b>VA Hospital, Ft. Howard, Md.</b>		DATE SIGNED <b>8/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. Blvd., Elk Ridge, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Harold A. Cole</b> ADDRESS <b>1913 W. Balto. St.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Colleen S. Kraus</b>			

COLE FUNERAL HOME 1913 W. Balto. St., Balto., Md.



8864

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08834

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>528 Shirley Manor Road</b>			d. STREET ADDRESS <b>528 Shirley Manor Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Allan Cleaveland Miles</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>31</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1930</b>		9. AGE (In years last birthday) <b>28 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Clarence P. Miles</b>			14. MOTHER'S MAIDEN NAME <b>Edna Maskill</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-28-5850</b>	17. INFORMANT Address <b>Mrs. Jacqueline Miles, Reisterstown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate Poisoning (self administered)</b> <b>970.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Mental Depression</b> (c) <b>24 hrs.?</b> DUE TO cause last. (c) <b>2 days</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>9-2-59</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>Sept. 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i>	



TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8865

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08835

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bridgeway Manor 5745 Edmondson Avenue		d. STREET ADDRESS 2918 Dunmurry Road	
3. NAME OF DECEASED (Type or print) First Middle Last ADOLPH MISICKA		4. DATE OF DEATH Month Day Year August 26 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1868
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret'd Foreman		10b. KIND OF BUSINESS OR INDUSTRY General Cigar Company, N.Y.	
11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT E. June Misicka, 2918 Dunmurry Road, Balto. 22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary thrombosis</i> (c) <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 1955, that I last saw the deceased alive on Aug 25, 1957, and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. <i>William Cook, Inc.</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8-29-59	
22c. NAME OF CEMETERY OR CREMATORY U.S. Crematorium		22d. LOCATION (City, town, or county) (State) Maspeth, Long Island, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE AUG 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			





8866

## CERTIFICATE OF DEATH

Reg. Dist. No.

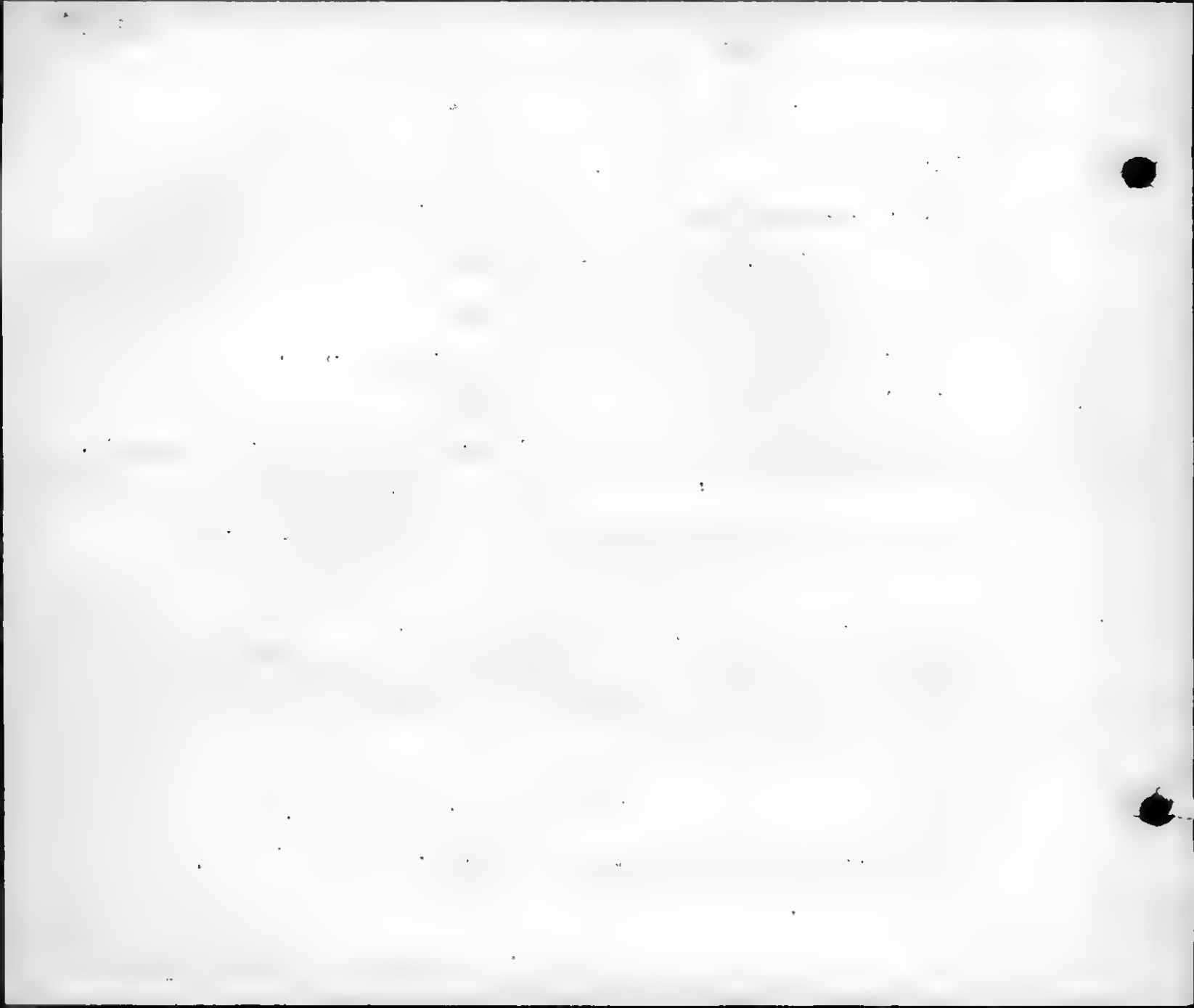
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cwings Mills</b>		c. LENGTH OF STAY IN 1b <b>19 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>- - -</b> Last <b>MORTON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/25</b>
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.	IF UNDER 24 HRS Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- - -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	11. BIRTHPLACE (State or foreign country) <b>Friendly House, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Morton, Howard</b>	
14. MOTHER'S MAIDEN NAME <b>Nellie Acton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>- - -</b>	
16. SOCIAL SECURITY NO. <b>- - -</b>		INFORMANT <b>Rosewood records</b> Address <b>Cwings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410 X</b> DUE TO <b>Mitral and aortic stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic heart disease</b> (c) <b>- - -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 Buttons in bronchial tree</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>19</b> , to <b>19</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:35 p.m.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Pete W. Rieckert</b> M.D.		ADDRESS (Street, city or town, state) <b>4307 Mainfield Ave</b> DATE SIGNED <b>8-26-59</b>	
PHYSICIAN'S NAME (Type) <b>Pete W. Rieckert</b>		Baltimore 14, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Curtis L. Hume</b>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



8867

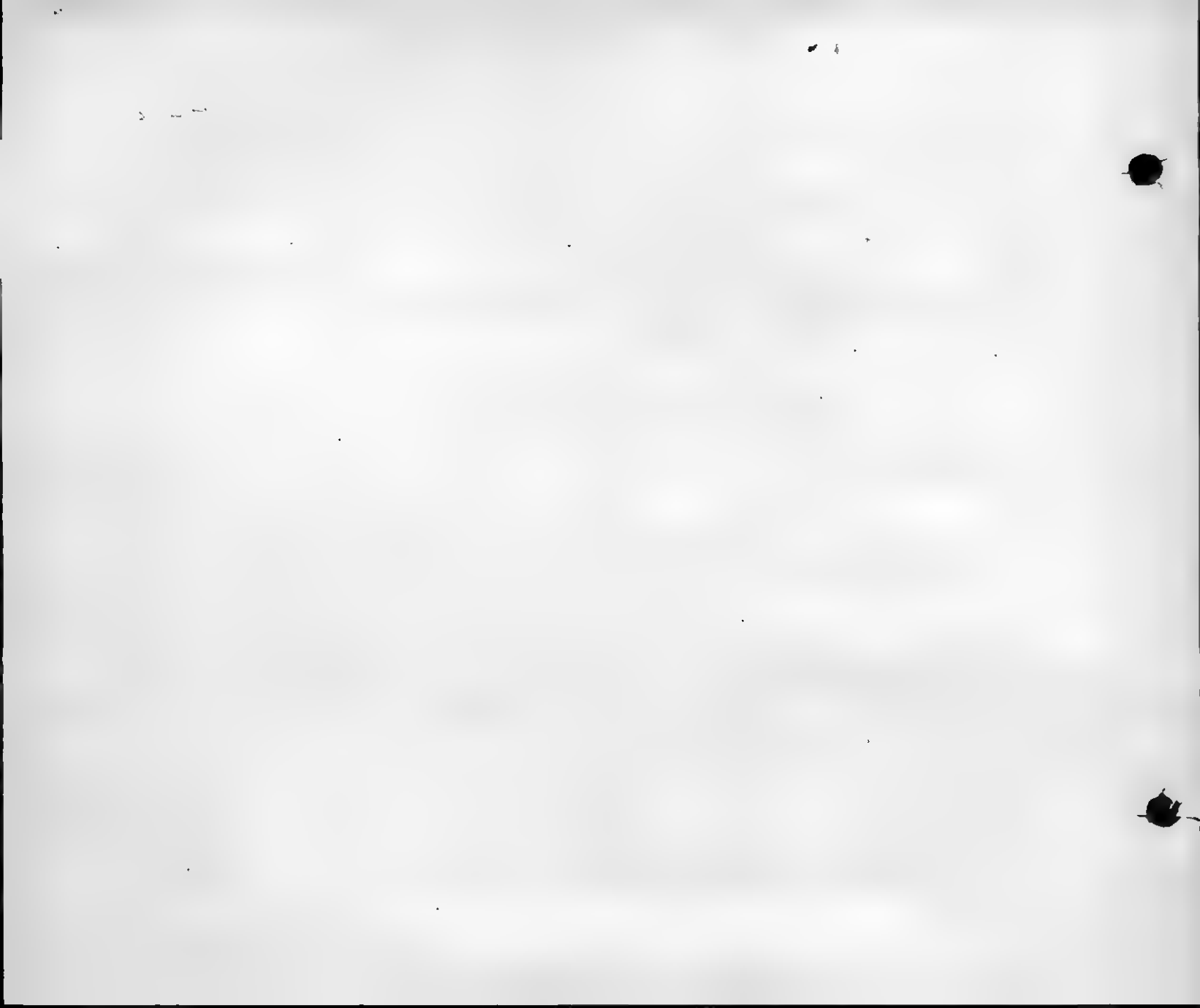
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>6 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>803 S. MARLYN AVE. (21)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH MOSLEY</u>		4. DATE OF DEATH Month Day Year <u>AUG 27 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-84</u>
9. AGE (in years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ALLEN BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA STREET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>THOMAS MOSLEY</u>		Address <u>803 S. MARLYN AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 1958</u> to <u>Aug. 1959</u> , that I last saw the deceased alive on <u>Aug. 27 1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2108 TREMONT ST. BALTIMORE MD.</u> <u>1/28/</u>			
ACTUAL SIGNATURE <u>Louis Semenovoff</u> M.D.		PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF BALTIMORE MD.</u>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BUTLER CEM. MITCHELL CO. N. C.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		24a. REC'D BY REGISTRAR <u>SEP 1 59</u>	24b. REGISTRAR'S SIGNATURE <u>John G. Connolly</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Page 1) and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8868

CERTIFICATE OF DEATH

08838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>2874</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>401 xing Island Ave</b>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium</b>		d. STREET ADDRESS <b>Balto 29 Mil</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET-Ann-MURRAY</b>		4. DATE OF DEATH Month Day Year <b>8 17 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 1930</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wilkes Barre Pa</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Murray</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudowood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b>			
526X DUE TO (b) <b>Bronchectasis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1958</b> to <b>Aug 17 1959</b> , that I last saw the deceased alive on <b>Aug 17 1959</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Eudowood Sanatorium, Towson 4, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller Inc.</b>		ADDRESS <b>2431-35 E. Oliver St.</b>	
24a. REC'D BY REGISTRAR <b>AUG 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8869

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>610 Murdock Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGINIA Etheridge NEWELL</u>		4. DATE OF DEATH Month Day Year <u>8 11 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/1886</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Henry Etheridge</u>		14. MOTHER'S MAIDEN NAME <u>CORA R. ALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Richard B. NEWELL</u>		Address <u>818 Hatherleigh Ct Baltimore-12-Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Essential Hypertension</u> DUE TO (c) <u>Atherosclerosis of C-V. Sys.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1955</u> to <u>August 11, 1959</u> , that I last saw the deceased alive on <u>August 11, 1959</u> , and that death occurred at <u>11:25 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Carr, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>6501 York Rd Baltimore-12</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles E. Carr, Jr., I.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u> ADDRESS <u>4905 Venable</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. S. H. H.</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician and completely filled in by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician.





8870

## CERTIFICATE OF DEATH

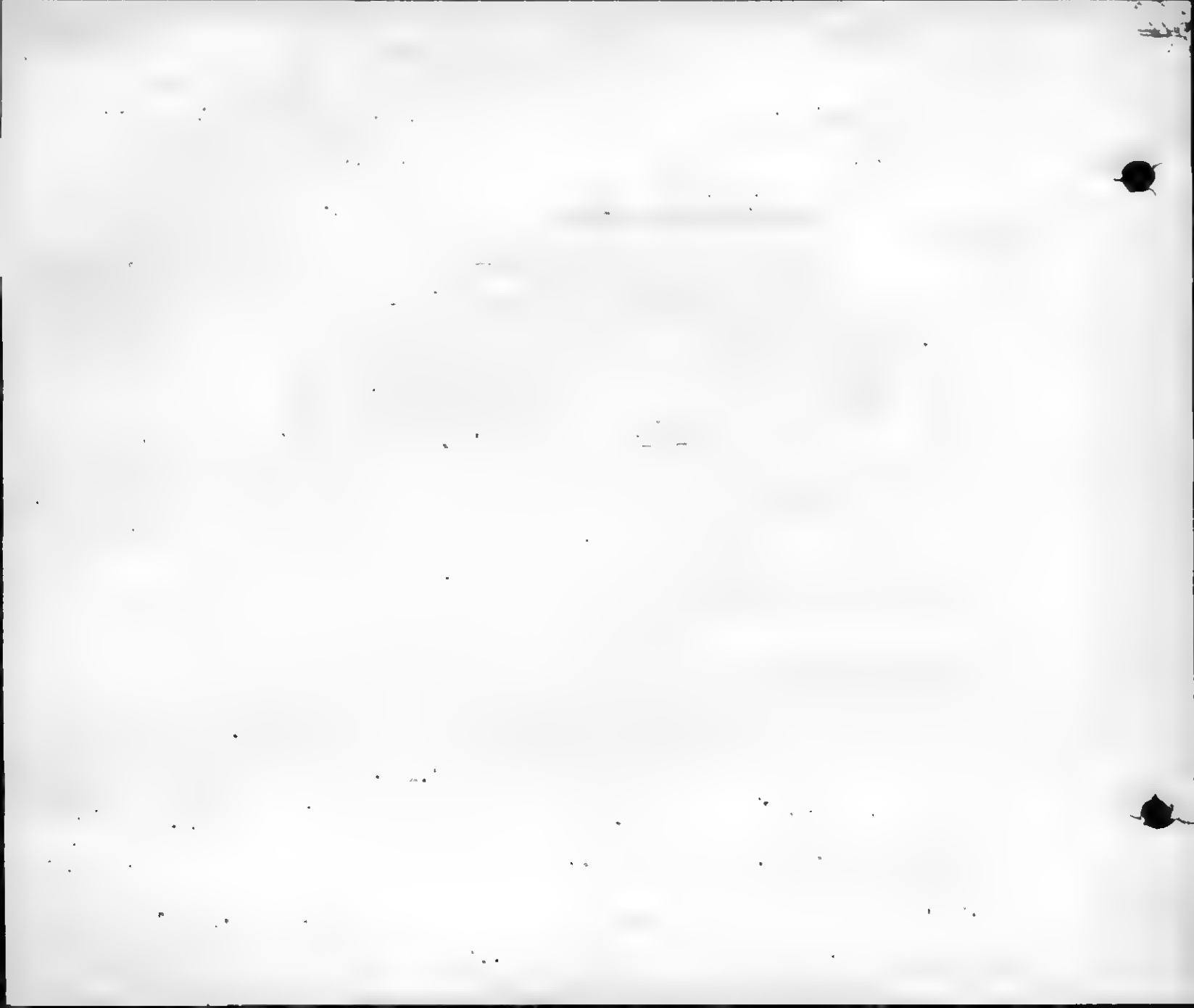
08840

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Idlewylde</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b> <b>301 West Chesapeake Avenue</b>		d. STREET ADDRESS <b>6301 Banbury Road</b>	
3. NAME OF DECEASED (Type or print) <b>Clara Florence Nickels</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13. FATHER'S NAME <b>Nelson Frederick</b>	
14. MOTHER'S MAIDEN NAME <b>Margaretta Garrett</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO. <b>213-34-5298A</b>		INFORMANT Address <b>Richard F. Nickels 6301 Banbury Road</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.3</b> DUE TO <b>1. NUTRITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause ost. DUE TO (b) <b>HEPATIC METASTASES, CARCINOMATOSIS</b> DUE TO (c) <b>ADENOCARCINOMA, COLON (SIGMOID)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>4 MONTHS</b> <b>6 MONTHS +</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/17/59</b> 19, to <b>8/30/59</b> 19, that I last saw the deceased alive on <b>8/26</b> 19 <b>59</b> , and that death occurred at <b>11:25 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald L. Somerville</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>25 W. Pa. Ave. Towson, Md. 8/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Donald L. Somerville, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 2, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Weishurg</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		24a REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>	24b REGISTRAR'S SIGNATURE <b>Charles E. Kenna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

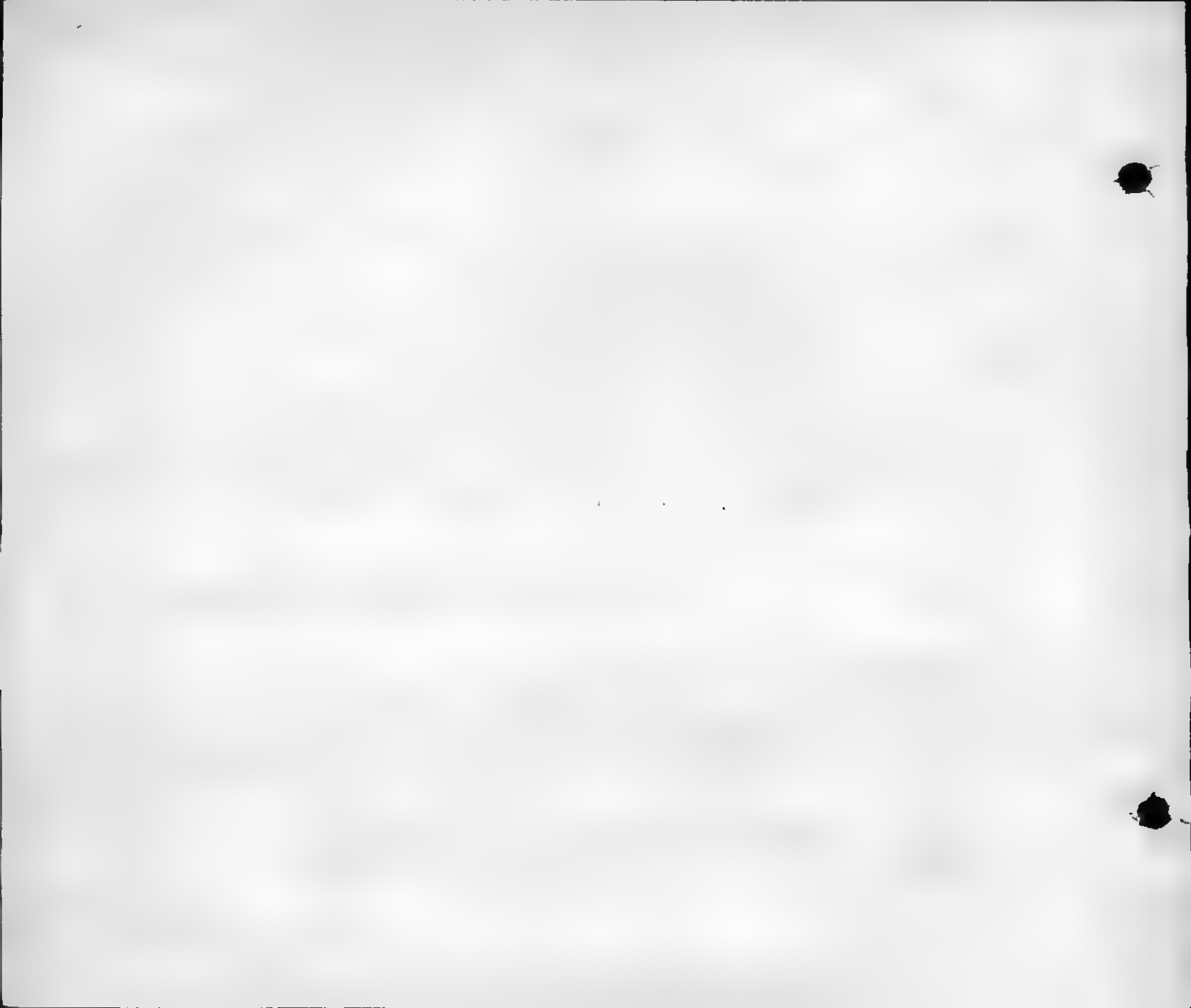
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8871 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COY ACQUISITION CO.</u>		d. STREET ADDRESS <u>604 JOSEPH ST NE</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY</u> First <u>FOULKE</u> Middle <u>ALICE</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POST OFFICE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM T VOLTE</u>		14. MOTHER'S MAIDEN NAME <u>FOULKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>WIFE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HANGING</u> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>16 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACCIDENTALISM</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William R. Kinsbury</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A PILSBURY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Spec 1) <u>Burial Aug 14, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook - Towson, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kins</u>	

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8767

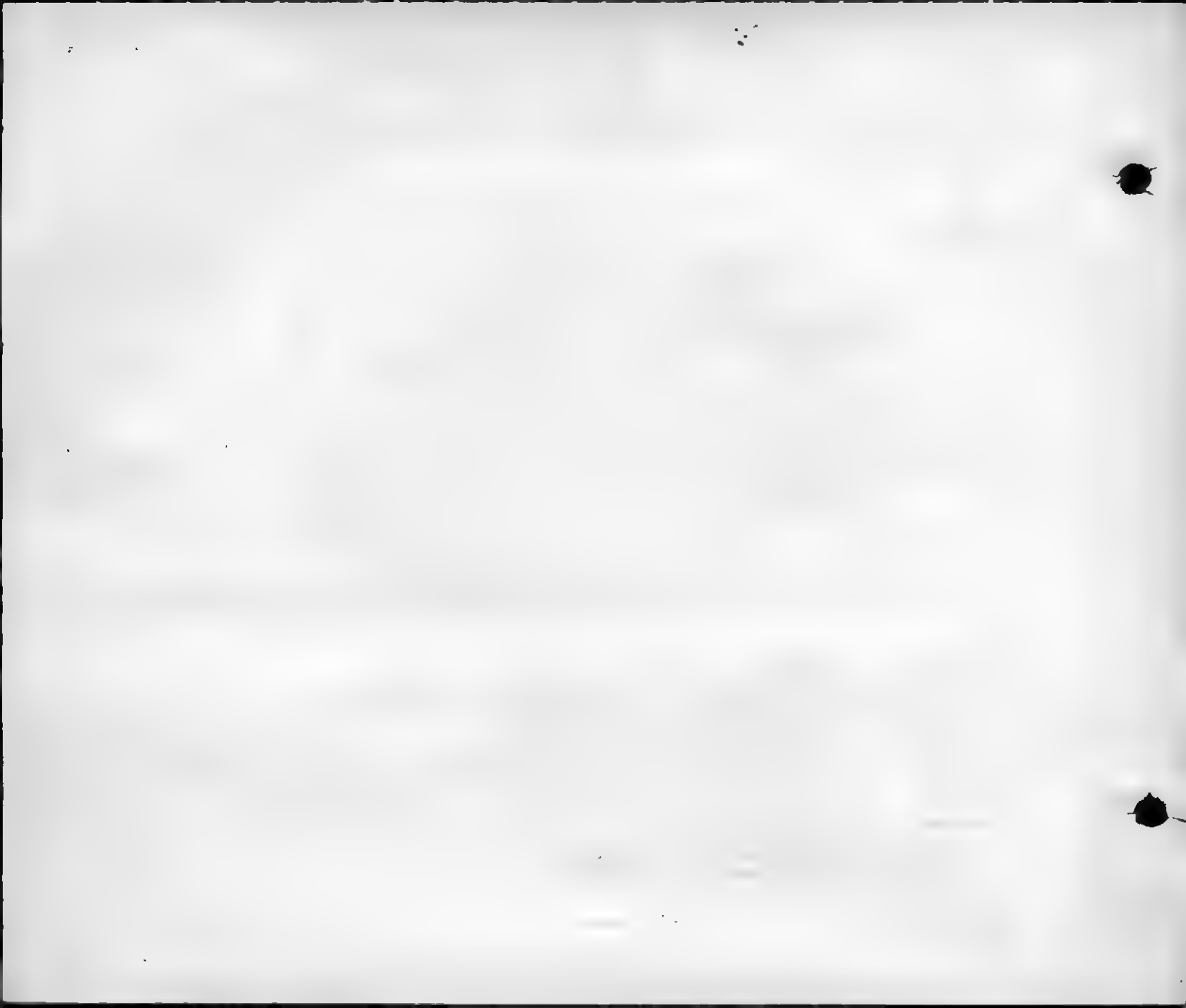
## CERTIFICATE OF DEATH

06842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1325 Main St</u>		d. STREET ADDRESS <u>1325 Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Owens</u> Last <u>Owens</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1901</u>
9. AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Owens</u>		14. MOTHER'S MAIDEN NAME <u>Constance Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>John Owens</u>		Address <u>1325 Main St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>HYPERTENSION, DIABETES MELLITUS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>22 AUGUST 1959</u> to <u>30 AUGUST 1959</u> that I last saw the deceased alive on <u>30 AUGUST 1959</u> , and that death occurred at <u>12:12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Givlean</u> M.D.		ADDRESS (Street, city or town, state) <u>Main St Ellicott City 27, Md.</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE E. GIVLEAN</u>		DATE SIGNED <u>31 AUG 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Owens</u>		ADDRESS <u>1325 Main St</u>	
24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Frank</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

8872

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn, Balto. 7</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn, Balto. 7</b>			
c. LENGTH OF STAY IN 1b <b>2 mos.</b>				d. STREET ADDRESS <b>6841 Dogwood Rd.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6841 Dogwood Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Earling</b> Last <b>Patterson, Sr.</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>white</b> <input checked="" type="checkbox"/> male	6. COLOR OR RACE <b>white</b> <input checked="" type="checkbox"/> male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1908</b>	9. AGE (in years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b>	IF UNDER 24 HRS Hours <b>1</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Calvert Distillery</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Ma.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Patterson</b>				14. MOTHER'S MAIDEN NAME <b>Ida May Reilly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-2364</b>		17. INFORMANT <b>Chas. E. Patterson, Jr.</b>			Address <b>Balto. 29 715 N. Woodington Rd.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>36 years</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Coles</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-25-59</b>			
EXAMINER'S NAME (Type) <b>D. D. Coles, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Ma.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR <b>Arthur L. Hines</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
ADDRESS <b>Balto. 7 Ellsworth Armacost, 4600 Lib. Hts. Ave.</b>				DATE <b>AUG 28 '59</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





8873

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2817 Delaware Ave.</b>		d. STREET ADDRESS <b>2817 Delaware Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Carrie Frances Perry</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 194</b>
9. AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Callis</b>		14. MOTHER'S MAIDEN NAME <b>--- Dies</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. E. F. Perry, Jr.</b>		Address <b>2817 Delaware Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Myocardial Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1959</b> to <b>Aug. 24, 1959</b> , that I last saw the deceased alive on <b>Aug. 24, 1959</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Y. K. YUAN, M. D., 3810 S. HANOVER ST., BALTIMORE 25, MARYLAND</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Y. K. Yuan</b>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC.</b>		ADDRESS <b>715 Light St.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kram</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>Woodlawn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3519 Sussex Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Randolph</b> Last <b>Randolph</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1959</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>21</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		DATE SIGNED <b>8/15/59</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Dorsey Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Funeral Home</b>		24a. REC'D BY REGISTRAR <b>SEP 28 59</b>	
ADDRESS <b>8728 Liberty Rd.,</b>		24b. REGISTRAR'S SIGNATURE <b>Living &amp; Trans</b>	

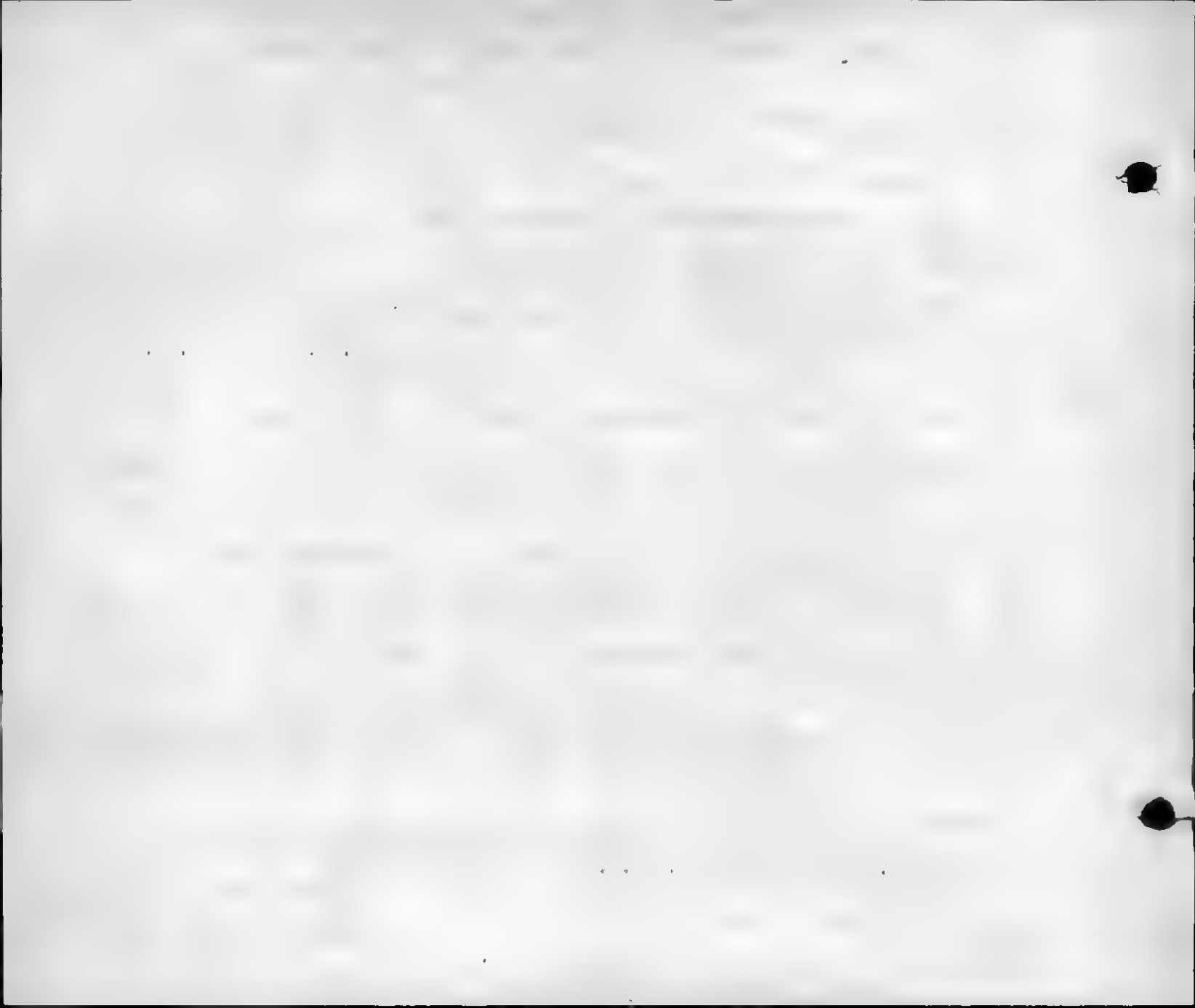
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5) 9/22/59  
SM 9/55

Mnb

9vvvvvvvvxv



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

8875

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>11yrlmth15dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Rasch</u> Last <u>Rasch</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 JUNE 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Frank Rasch</u>		14. MOTHER'S MAIDEN NAME <u>Anna Grochnal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 44-X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1959</u> to <u>Aug. 18, 1959</u> , that I last saw the deceased alive on <u>Aug. 18, 1959</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isadore Tuerk</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8-18-59</u>	
PHYSICIAN'S NAME (Type) <u>Isadore Tuerk, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 21/59 Holy Rosary</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozgowski</u>		24a. REC'D BY REGISTRAR <u>1930</u>	
24b. REGISTRAR'S SIGNATURE <u>Callum &amp; Hines</u>		DATE <u>AUG 20 '59</u>	









8877

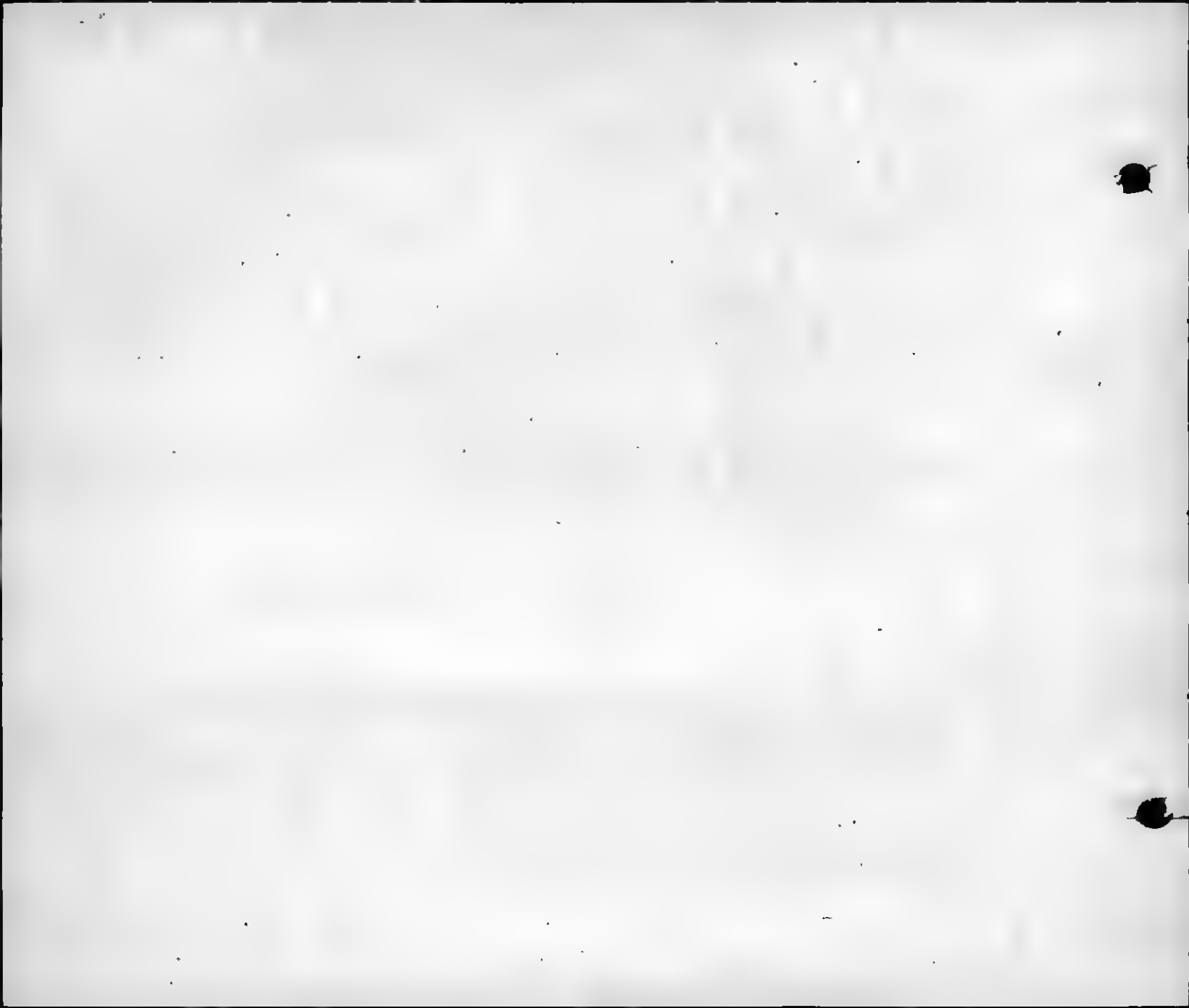
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7436 KENLEA AVE.</b>		e. STREET ADDRESS <b>7436 KENLEA AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>MERLE</b> Middle <b>E.</b> Last <b>REED</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16-1888</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WOODWORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PITTSBURGH PLATE</b>	
11. BIRTHPLACE (State or foreign country) <b>KENE PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS REED</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE CASPER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-05-2934</b>	
17. INFORMANT <b>CLARA M. REED</b>		Address <b>7436 KENLEA AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer, esophageal varices</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-7-1959</b> , to <b>8-7-1959</b> , that I last saw the deceased alive on <b>8-7-1959</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Santi Amoroso</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>6801 Belair Road, Balto. 6 8-8-59</b>	
PHYSICIAN'S NAME (Type) <b>Santi Amoroso</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-10-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Fun'l Home</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

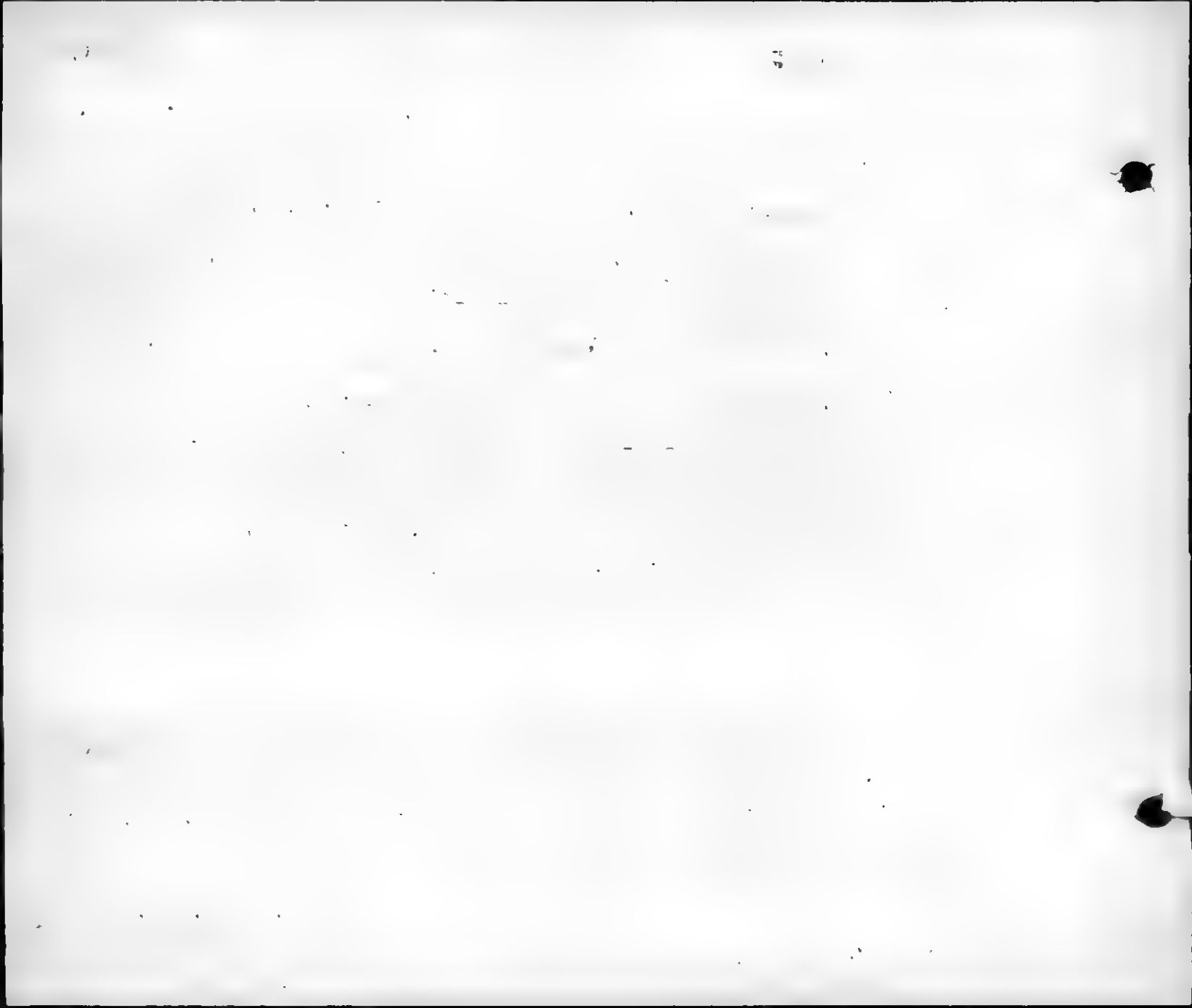
## CERTIFICATE OF DEATH

08848  
Reg. Dist. No.

8878

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>-2 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 Ingleside Ave.</u>		d. STREET ADDRESS <u>309 Ingleside Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Reinhard</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Reinhard</u>		14. MOTHER'S MAIDEN NAME <u>Emily Francis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>578-07-6602</u>	
INFORMANT <u>Mrs Naomi Reinhard</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. <u>&amp; Cerebral arteriosclerosis</u> DUE TO (b) <u>6 years</u> DUE TO (c) <u>6 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> 19 <u>58</u> to <u>Aug 14</u> 19 <u>59</u> that I last saw the deceased alive on <u>Aug 13</u> 19 <u>59</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard Wallenstein, M.D.</u>		ADDRESS (Street, city or town, state) <u>848 W 36th St Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>LEONARD WALLENSTEIN, M.D.</u>		DATE SIGNED <u>AUG 18 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>AUG 18 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8879

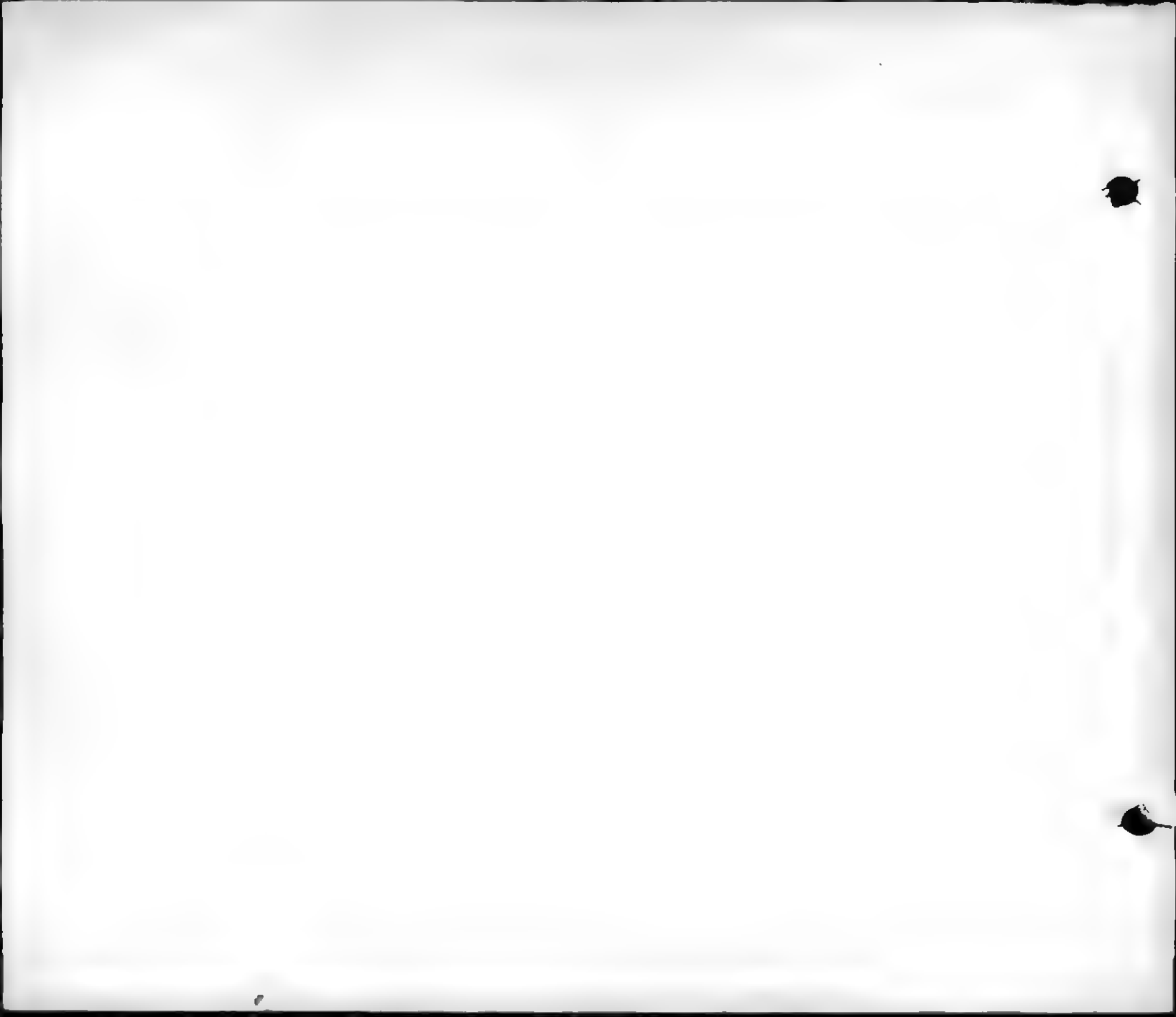
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print)		ELLA CECILIA ROONEY		2. DATE OF DEATH		AUG 26, 1959	
3. PLACE OF DEATH: A. Baltimore, City, Maryland		217 BLENHEIM RD, 12		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		MARYLAND BALTO.	
B. FULL NAME OF HOSPITAL OR INSTITUTION		Baltimore County - Balto - 12		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		BALTIMORE	
c Length of stay in Baltimore		41 yrs		D. STREET ADDRESS (If rural, give location)		217 BLENHEIM RD, BALTO 12 MD	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months	11. Under 24 Hours	12. Under 24 Hours Min.
F	W	Widow	AUG 17, 1888	71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		—		BALTIMORE MD		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DENNIS DRISCOLL				CATHERINE FENTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		—		DR. MARIUS P JOHNSON		222 MED ARTS BLDG	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) UREMIA		INTERVAL BETWEEN ONSET AND DEATH		7 days	
176.0 ANTECEDENT CAUSES		(B) CARCINOMA OF VULVA					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST		(C) OPERATION - VULVECTOMY					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		APRIL 1959 - METASTASES OF CARCINOMA					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER TO PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I certify that (I) (the hospital) attended the deceased from APRIL 1959 to AUG. 26 1959, that (I) (we) last saw the deceased alive on AUG. 24 1959, and that death occurred at 6:30 P.M., from the causes and on the date stated above							
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED			
Marius P. Johnson M.D.		222 Med. Arts Bldg BALTO. 1 MD		AUG 27, 1959			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/29/59		CATHEDRAL CEM		BALTO -	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
S. C.		Arthur S. Thomas		Heidrick & Sons			

THIS IS A PERMANENT RECORD. PLEASE TYPE IN PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



**X-1 M**  
FOR STATE  
HEALTH DEPT.

8880

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>18</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth16dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1925 Linden Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Louis Rosen</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b>
9. AGE (In years last birthday) <b>82 yrs</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>small bldgs.</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>703.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular disease</b> (c) <b>Accidental fracture right hip</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shoved to the floor on 7-21-59 by another patient, sustaining frac. right femur</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:05</b> Hour <b>306</b> p. m. <b>7-21-59</b> 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-5-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Bald. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc. 2100 Eastern Place.</b>		24a. REC'D BY REGISTRAR <b>AUG 6 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





8881

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>73 North Monastery Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>John</b> <b>Saum, Jr.</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 13, 1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	9. AGE (In years last birthday) yrs. <b>39</b>
13. FATHER'S NAME <b>John Saum, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Middlecamp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-89-9477</b>	
17. DEFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO (b) <b>General paresis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug. 22, 1959</b> , to <b>Aug. 25, 1959</b> , that I last saw the deceased alive on <b>Aug. 25, 1959</b> , and that death occurred at <b>4:25a</b> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>8-25-59</b>
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
<b>Burial Aug 28, 1959</b>	<b>Balt. National</b>	<b>Stella Wachsler</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wappert Funeral Home - 1300 E. E. Ave.</b>		24a. REC'D BY REGISTRAR <b>AUG 31 1959</b>
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



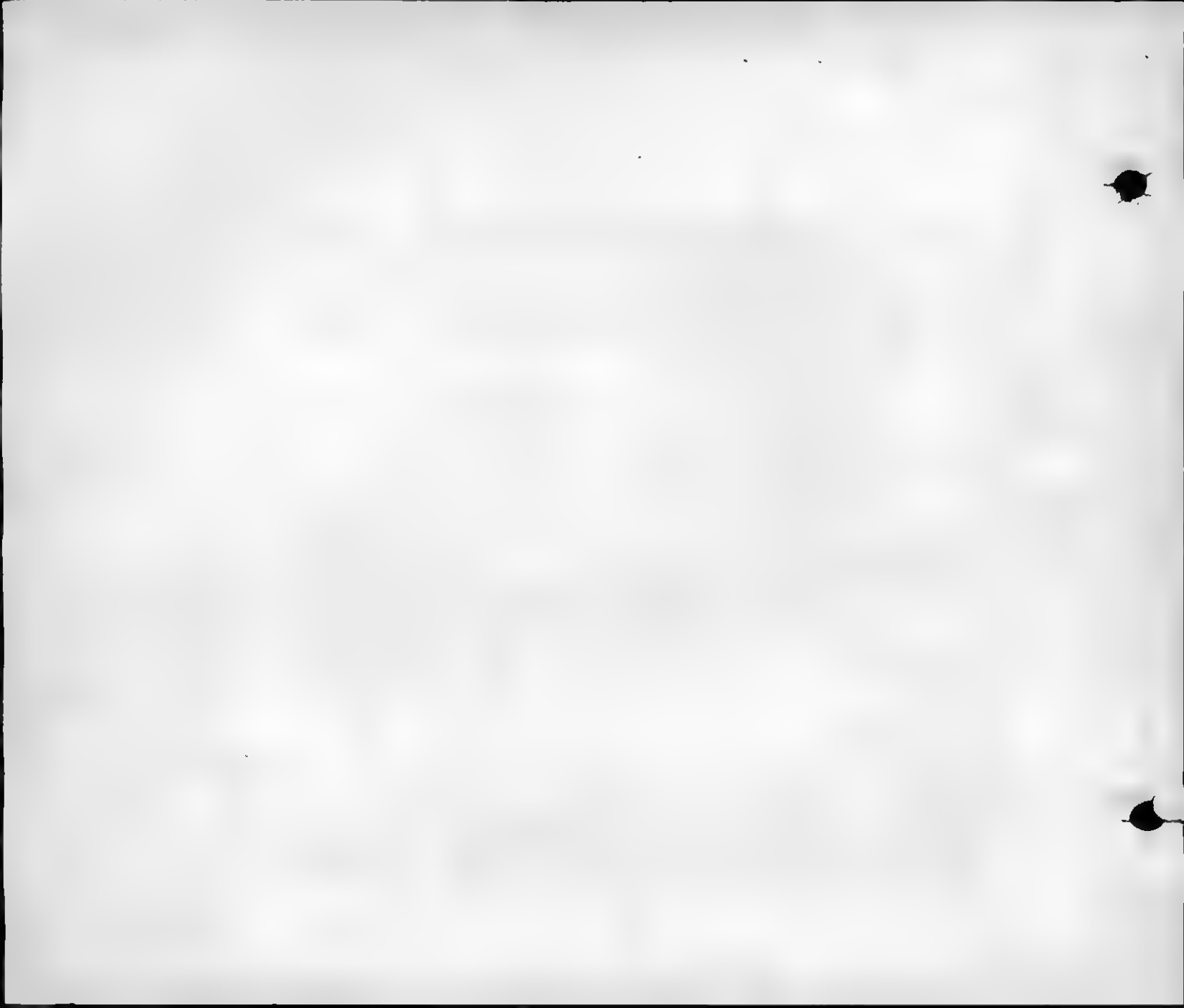
06852

FOR STATE  
HEALTH DEPT.

2882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Chase, Md</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rosedale zone 6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1001 Beachdale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Daniel Charles Savage</u>		4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-33</u>
9. AGE (In years last birthday) <u>25</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Savage</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Grebowski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-30-8363</u>	
17. INFORMANT <u>Margaret J. Savage</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>924.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dived from Boat, came up near + same -</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:45 p.m. 8-14 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Supermarket</u>		20f. CITY or town <u>Chase</u>	
(County) <u>Balto.</u>		(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M B Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M B DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos F. Busch</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 18 '59</u>	
ADDRESS <u>1211 Chesebrough Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



8883

## CERTIFICATE OF DEATH

08853

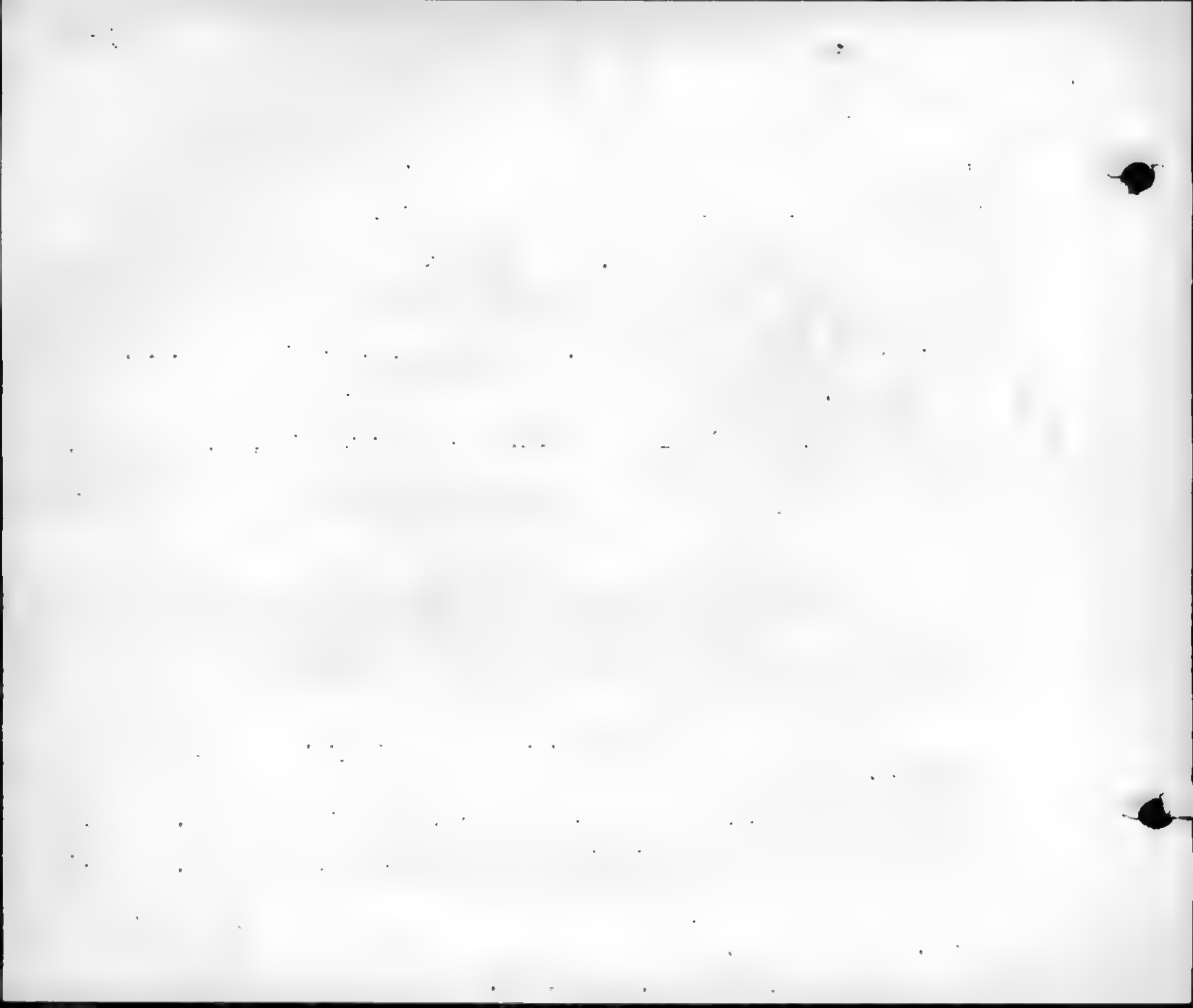
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>40 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>A.</b> Last <b>SCHAEFER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1908</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob J. Schaefer</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Nicholas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Yes ---</b>	
INFORMANT <b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		LAENNEC'S CIRRHOSIS DIABETES MELLITUS Interval between onset and death <b>Unknown</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>August 9, 1959</b> , to <b>August 9, 1959</b> , and that death occurred at <b>1:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Caridad E. Gomez</i> M.D.		DATE SIGNED <b>8/9/59</b>	
PHYSICIAN'S NAME (Type) <b>VA Hospital, Ft. Howard, Md.</b>		<b>8/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran - 3000 E. Baltimore Street</b>		24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kirsch</i>

JOHN A. MORAN, 3000 E. Balto. St., Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8884 1 Items 3,10,11,12,13,14,16 Fill 8-24-59  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

08854

Reg. Dist. No.

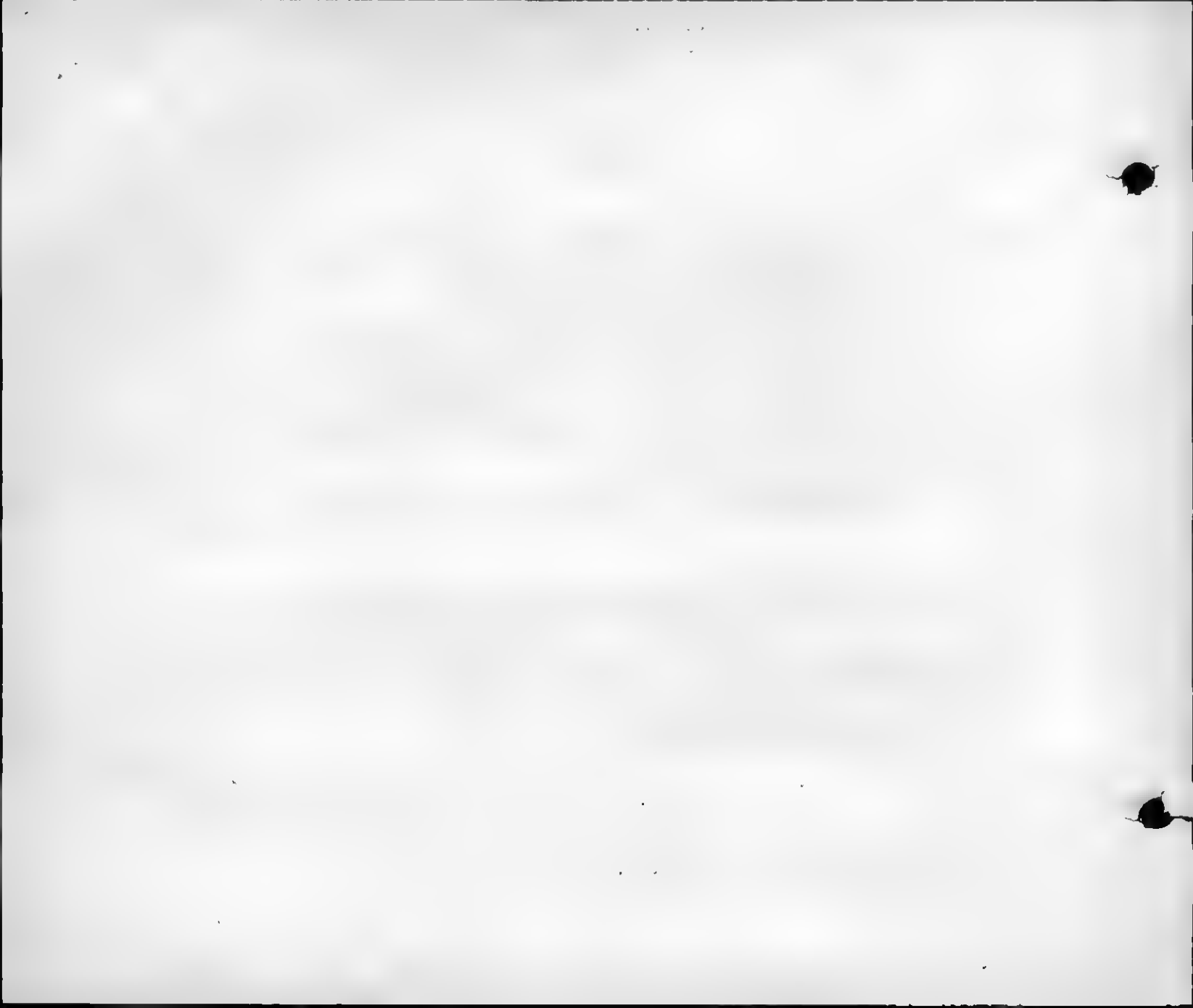
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2mths10days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>4404 Eldron Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Schapiro</u> Middle <u>Jacob</u> Last <u>Schapiro</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>26</u> - Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	9. AGE (In years last birthday) yrs <u>62</u>
11. BIRTHPLACE (State or foreign country) <u>Unknown Bel Air, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Jacob Schapiro</u>		14. MOTHER'S MAIDEN NAME <u>Bertha ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-05-3168</u>	
17. INFORMANT <u>Records : SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL DEBILITY</u> (c) <u>GENERAL VASCULAR ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 5</u> , 19 <u>59</u> , to <u>Aug 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG 26</u> , 19 <u>59</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>P. K. Yip</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>P. K. YIP, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-28-59</u>	<u>Baltimore Hebrew</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Canton Place</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 27 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Hurd</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









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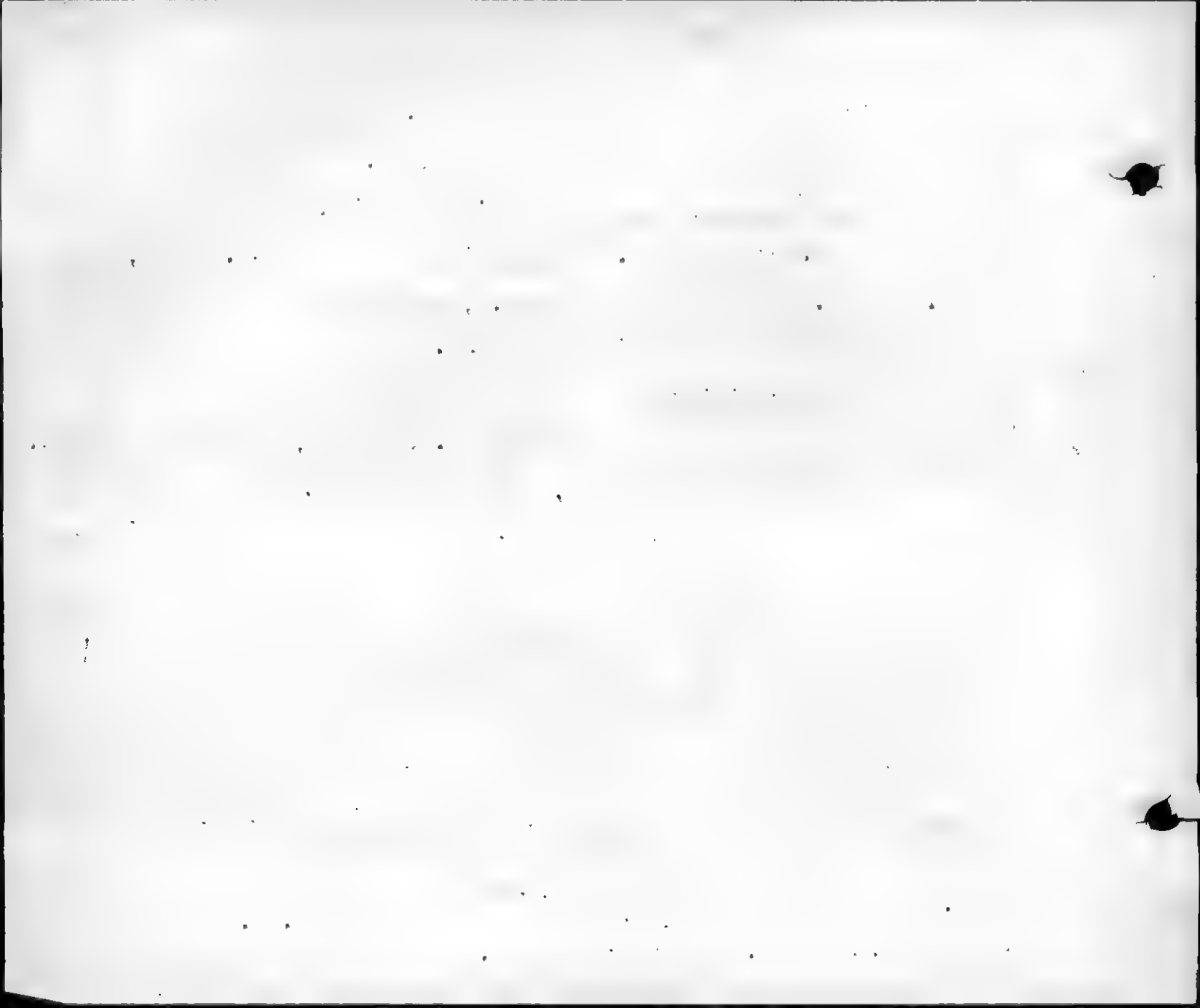
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8886 CERTIFICATE OF DEATH									
Reg. Dist. No. 08856									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b> <b>5748 Edmondson Ave</b>					d. STREET ADDRESS <b>Balto.</b> <b>3212 Strickland St</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Charles H. Schlining</b>					4. DATE OF DEATH <b>Aug. 21, 1959</b>				
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sign Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Louis Schlining</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Charles K. Schlining, 3205 Strickland St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>									
DUE TO (b) <b>Brain disease</b>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1951</b> , 19, to <b>Aug 21</b> , 19, that I last saw the deceased alive on <b>8/21</b> , 19, and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>3326 Indebank Ave</b> DATE SIGNED									
ACTUAL SIGNATURE <b>Thomas P. Hayes</b>									
PHYSICIAN'S NAME (Type) <b>Witzke Funeral Dir.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louder Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>						24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

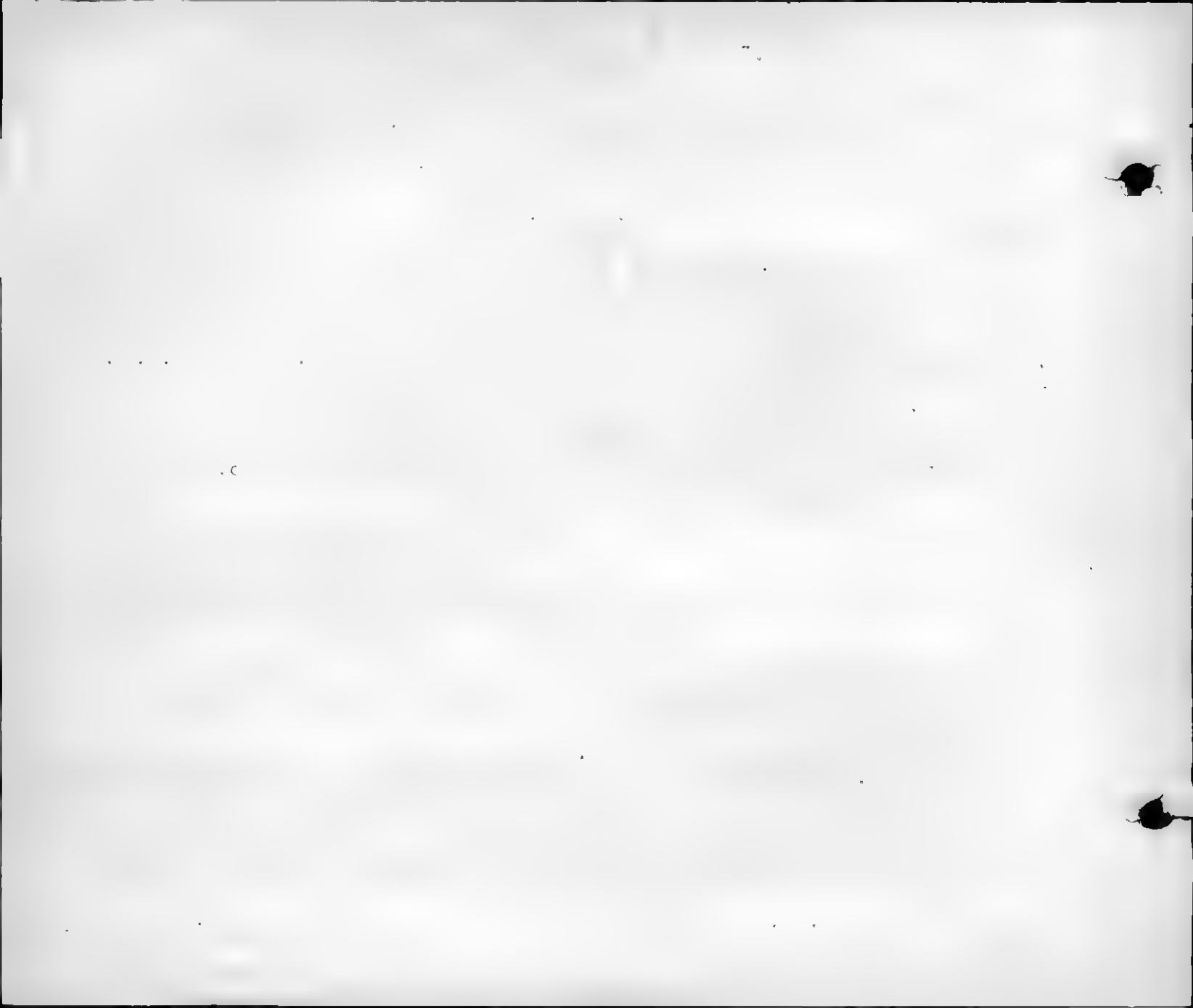
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8887

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armaccost Nursing Home Register Ave. 8329 Merrymount Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK B. SCHNAPP</b>				4. DATE OF DEATH <b>August 8, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wilkes Barre Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>J. Bernard Schnapp</b>			
14. MOTHER'S MAIDEN NAME <b>Charolette Nellius</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>212-10-9220</b>				17. INFORMANT <b>Elizabeth Magdalene Schnapp</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>8329 Merrymount Drive Balto. 7,</b>							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> 180X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse hepatic metastases with ascites</b> 1 month							
(c) <b>Renal cell carcinoma with metastases</b> 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 <b>Aug 8 1959</b>							
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug. 5, 1959, to Aug 8, 1959</b> that I last saw the deceased alive on <b>Aug. 8, 1959</b> , and that death occurred at <b>7:11 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Dirk Van Peenen MD</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dirk Van Peenen</b> <b>1008 Register Avenue</b> <b>8/9/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Saint Nicholas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shavertown, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armaccost</b> ADDRESS <b>4600 Liberty Heights</b>				24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



8888

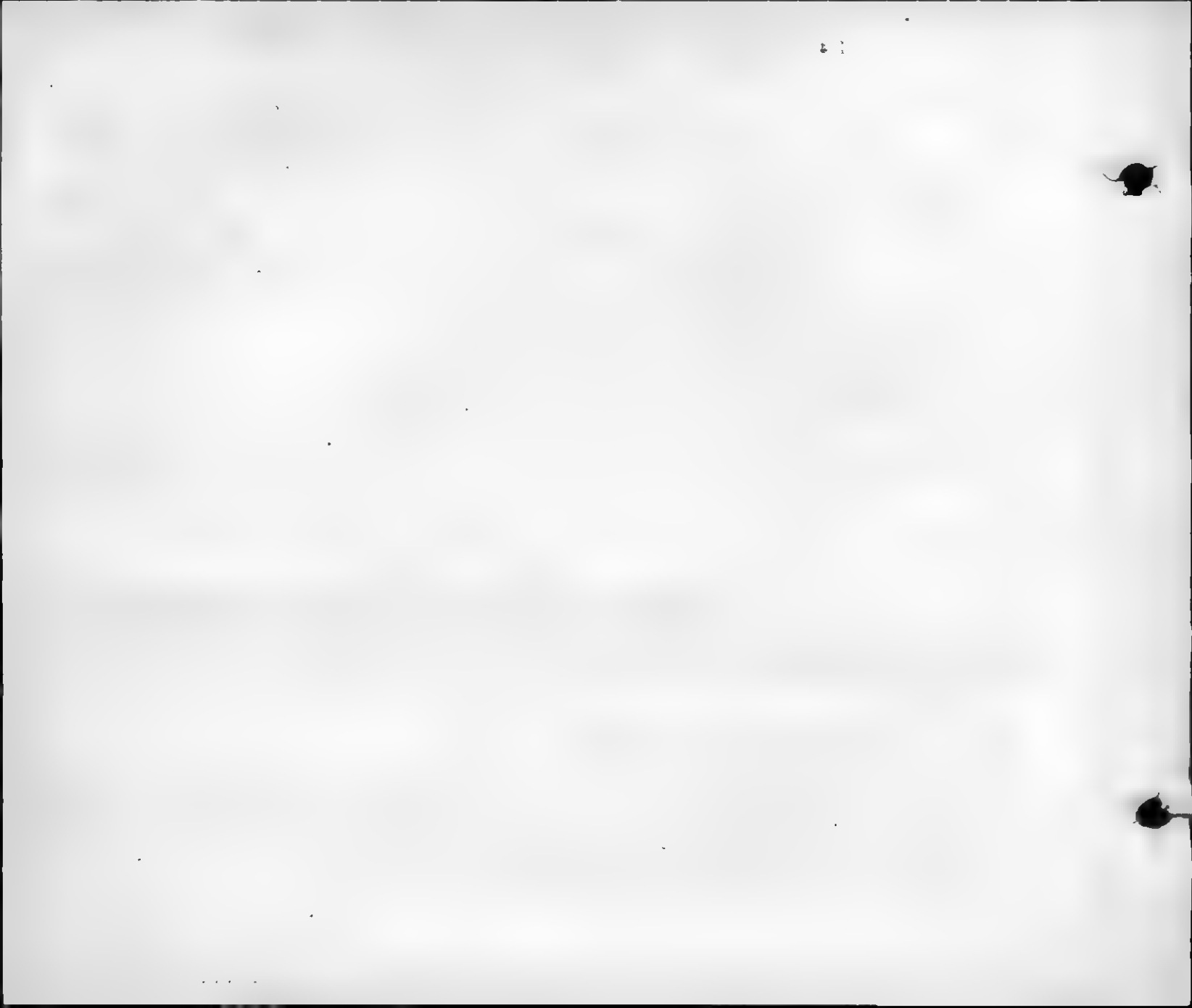
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto Co Md</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2808 Louisanna Ave English Consul Balto Co Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Calonsville</b>		c. LENGTH OF STAY IN 1b <b>5 wks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Nursing Home</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Florence E Schwartz</b>		4. DATE OF DEATH <b>Aug. 16-1959</b> 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1878 ? 81 yrs</b>
9. AGE (In years lost birthday) <b>81 yrs</b>		10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS <b>Days</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Co Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Wade</b>		14. MOTHER'S MAIDEN NAME <b>Susian Kesler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes, give war or dates of service</b>		16. SOCIAL SECURITY NO. <b>Frank J Schwartz 2808 Louisanna Ave Balto Co Md</b>	
17. INFORMANT <b>Frank J Schwartz 2808 Louisanna Ave Balto Co Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4x</b> DUE TO <b>Arteriosclerotic cerebrovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 200</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 14, 1959</b> , to <b>August 16, 1959</b> , that I last saw the deceased alive on <b>August 14, 1959</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>8-17-59</b>	
ACTUAL SIGNATURE <b>J. Nelson Nickay</b> M.D. <b>6047</b>		PHYSICIAN'S NAME (Type) <b>J. Nelson Nickay M.D. 6047</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Washington Blvd Elkridge Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edwa rd Toulson</b>		ADDRESS <b>2359 Wash Blvd Balto 30 Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Catharine E. Kline</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8889

## CERTIFICATE OF DEATH

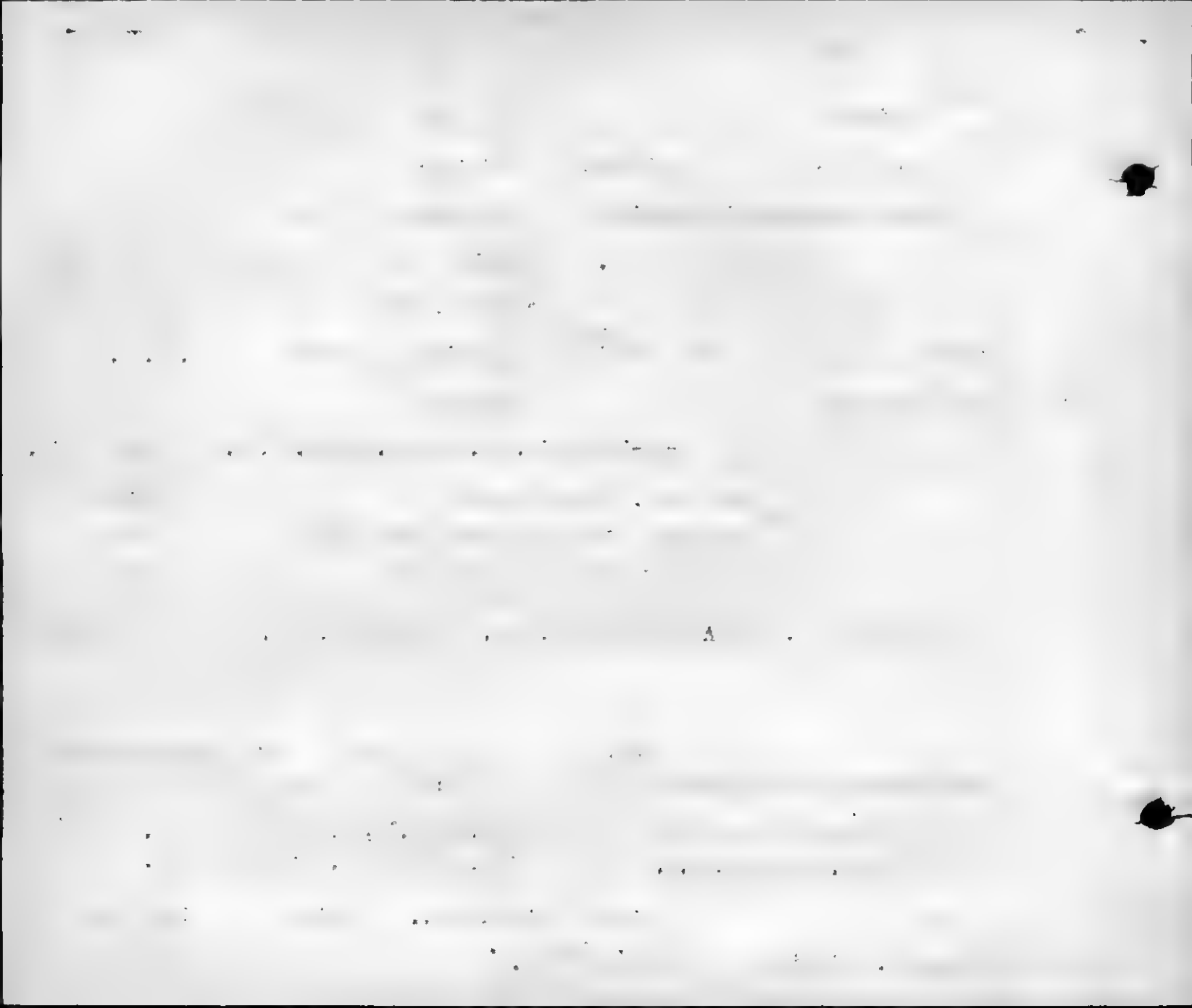
08859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>171 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>616 Reservoir Street</b>	
3. NAME OF DECEASED (Type or print) <b>VERNON E. SEABORNE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 7, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plant Dry Cleaning /</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Seaborne</b>		14. MOTHER'S MAIDEN NAME <b>Sara Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>216-01-3981</b>	
17. INFORMANT <b>Clin. Rec. VA Hosp., Balto. 18, Md. Fort Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, FLOOR OF MOUTH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY INFARCTION, RIGHT LOWER LOBE</b> (c) <b>PULMONARY CONGESTION AND EDEMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>RECENT</b> <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, MODERATELY ADVANCED, OLD. EMACIATION, OLD.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 13</b> , 19 <b>59</b> , to <b>August 31</b> , 19 <b>59</b> , and that death occurred at <b>8:05 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD, FORT HOWARD DIV. 9/1/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kruus</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

8890

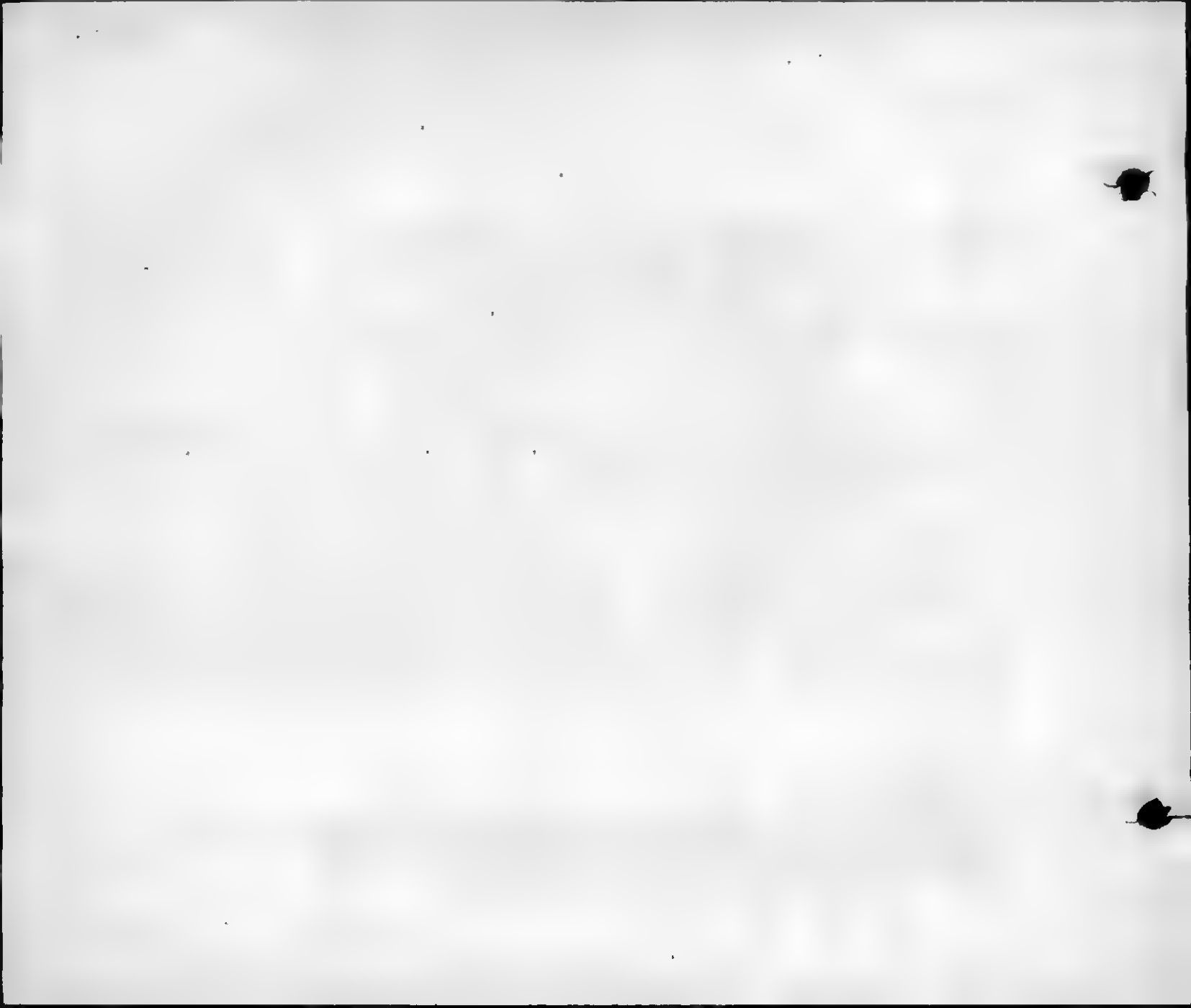
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>		c. LENGTH OF STAY IN 1b <u>20 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Ridgeway AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>James William Seal</u>		4. DATE OF DEATH <u>August 19, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Herb Shipley</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Seal</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Seal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>217-125796</u>	
17. INFORMANT <u>Mr. Marvin Seal, Ridgeway Ave., Lutherville</u>		Address <u>Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		DATE SIGNED <u>8/20/59</u>	
EXAMINER'S NAME (Type) <u>MARTIN E. STROBEL</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 22, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Foodlam, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>AUG 24 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8891

## CERTIFICATE OF DEATH

08861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2917 Topaz Road</b>		d. STREET ADDRESS <b>2917 Topaz Road #14</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>J.</b> Last <b>SHEPPARD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Person</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martha Washington Ice Cream Stores Balto. Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Howard Wright</b>		14. MOTHER'S MAIDEN NAME <b>Laura Yost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-22-6023</b>	
17. INFORMANT <b>Mr. Elmer W. Sheppard-2917 Topaz Road #14</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive S. V. Disease</b> (c) <b>Diabetic Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1949</b> to <b>Aug. 11, 1959</b> , that I last saw the deceased alive on <b>Aug. 11, 1959</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Nathan J. J. J.</b> M.D.		ADDRESS (Street, city or town, state) <b>7101 Harford Rd.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>8/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. J. J.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christ S. J. J.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

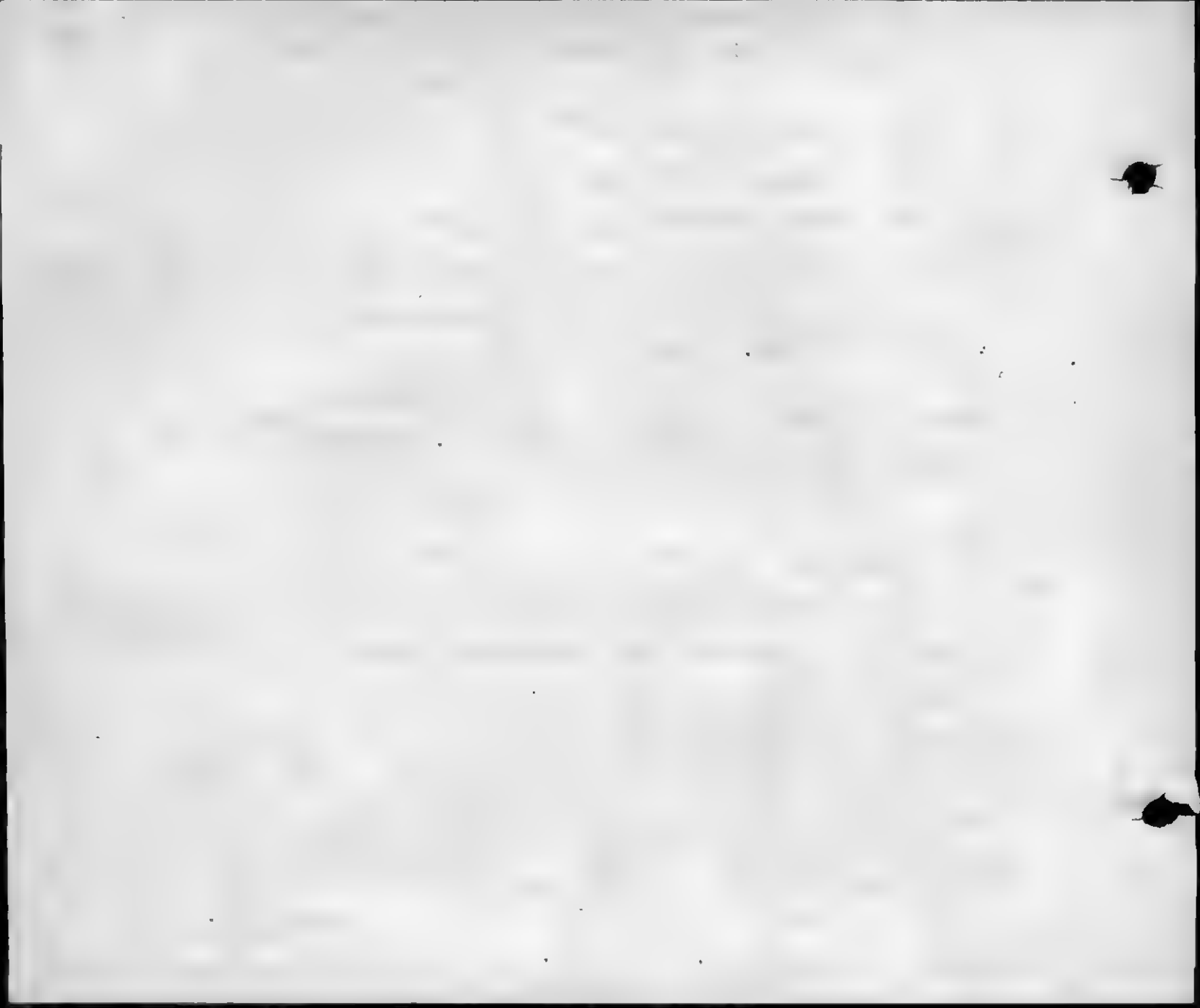
VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8892 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PHOENIX</b>	c. LENGTH OF STAY IN 1b <b>life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X PHOENIX</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>COOPER RD</b>		d. STREET ADDRESS <b>1 COOPER RD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CARROLL</b> Last <b>SHEPPERD</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER mang.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm dairy</b>	9. AGE (In years last birthday) <b>59 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILMER D. SHEPPERD</b>		14. MOTHER'S MAIDEN NAME <b>Alice Watson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Eleanor P. Shepperd,</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4:20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		DATE SIGNED <b>8/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Clynnaliam Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Phoenix, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8893

## CERTIFICATE OF DEATH

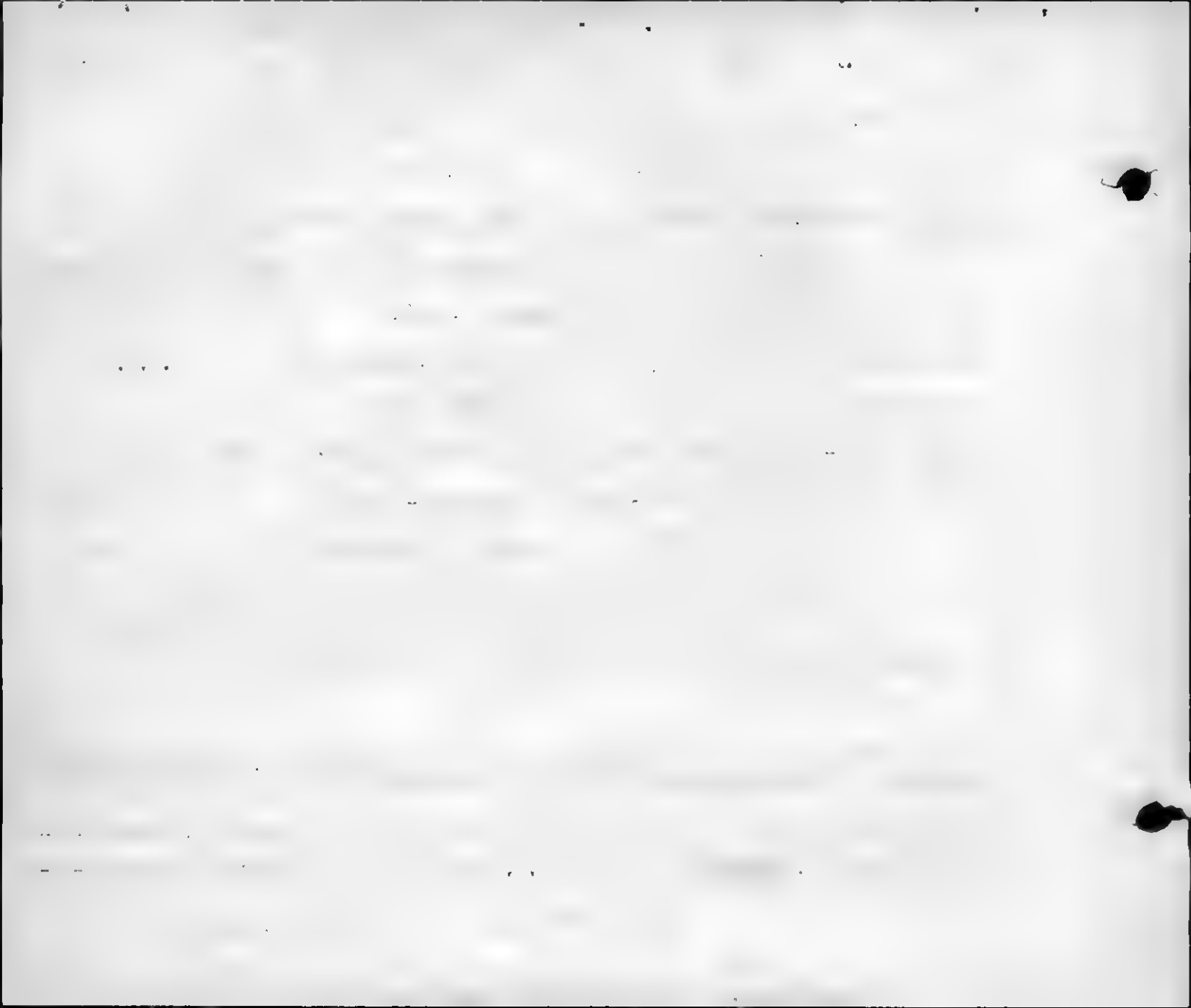
Reg. Dist. No.

08863

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>121 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
f. STREET ADDRESS <b>1077 ELLICOTT DRIVEWAY</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>F</b> Last <b>SHOWELL</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>DENTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SHOWELL</b>		14. MOTHER'S MAIDEN NAME <b>EDITH TURPIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-II</b>		16. SOCIAL SECURITY NO. <b>219-01-7018</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD-FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERIPHERO-VASCULAR COLLAPSE - SHOCK</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMATOSIS (ANAPLASTIC CARCINOMA)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b> <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22, 1959</b> , to <b>August 21, 1959</b> , and that death occurred on the date stated above <b>10:55 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Samuel J. Mangus</b>		M.D. <b>VAH Ft. Howard Maryland 8-22-59</b>	
PHYSICIAN'S NAME (Type) <b>Samuel J. Mangus</b>		M.D. <b>VAH Ft. Howard Maryland 8-22-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. G. Kelson</b>		24a. REC'D BY REGISTRAR <b>1348 N. Calhoun St</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Frank</b>		DATE <b>AUG 27 '59</b>	

George G Kelson Funeral Home, 1348 N Calhoun St Baltimore 17 Md

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08864

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN lb <b>5 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2903 Dunmore Road</b>		d. STREET ADDRESS <b>2903 Dunmore Road</b>	
3. NAME OF DECEASED (Type or print) <b>ESTELLE BELLE SIGMOND</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3rd</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>	
13. FATHER'S NAME <b>Felix Shorff</b>		14. MOTHER'S MAIDEN NAME <b>Mary ???</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>John Sigmond</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Coronary Artery Disease</b> <b>42 yrs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Coronary Artery Disease</b> DUE TO (c) <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C. Collins, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Raymonds Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bronx, New York, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 5 '59</b>	
ADDRESS <b>Dundalk 22, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08865

8894

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KINGSVILLE - MD</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bowles Farm, Jerusalem Road</b>				d. STREET ADDRESS <b>Bowles Farm, Jerusalem Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>C.</b> Last <b>SMALL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-24-1895</b>	9. AGE (in years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>3</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALEC SMALL</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN MOSSBERG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>DAVID SMALL 15 BLADE AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>PARTIAL</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>o. m. p. m.</b> Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PARTIAL</b>		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/25/59</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. CHRISTIAN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HARFORD CO. MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lavanthum</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8895

## CERTIFICATE OF DEATH

08866

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>SMITH</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 9, 1924</b>	
9. AGE (In years last birthday) yrs <b>35</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>13</b> Hours <b>19</b> Min <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Govt. Soc. Sec.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>John B. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>216-16-9636</b>		17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT NEPHROSCLEROSIS WITH UREMIA</b> DUE TO <b>MALIGNANT HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CARDIAC FAILURE</b> (b) <b>CARDIAC FAILURE</b> (c) <b>CARDIAC FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>UNKNOWN</b> <b>RECENT</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 5, 1959</b> to <b>August 13, 1959</b> and that death occurred at <b>7:50 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>				DATE SIGNED <b>8/14/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				24a. REC'D BY REGISTRAR <b>17</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. L. Frank</b>	

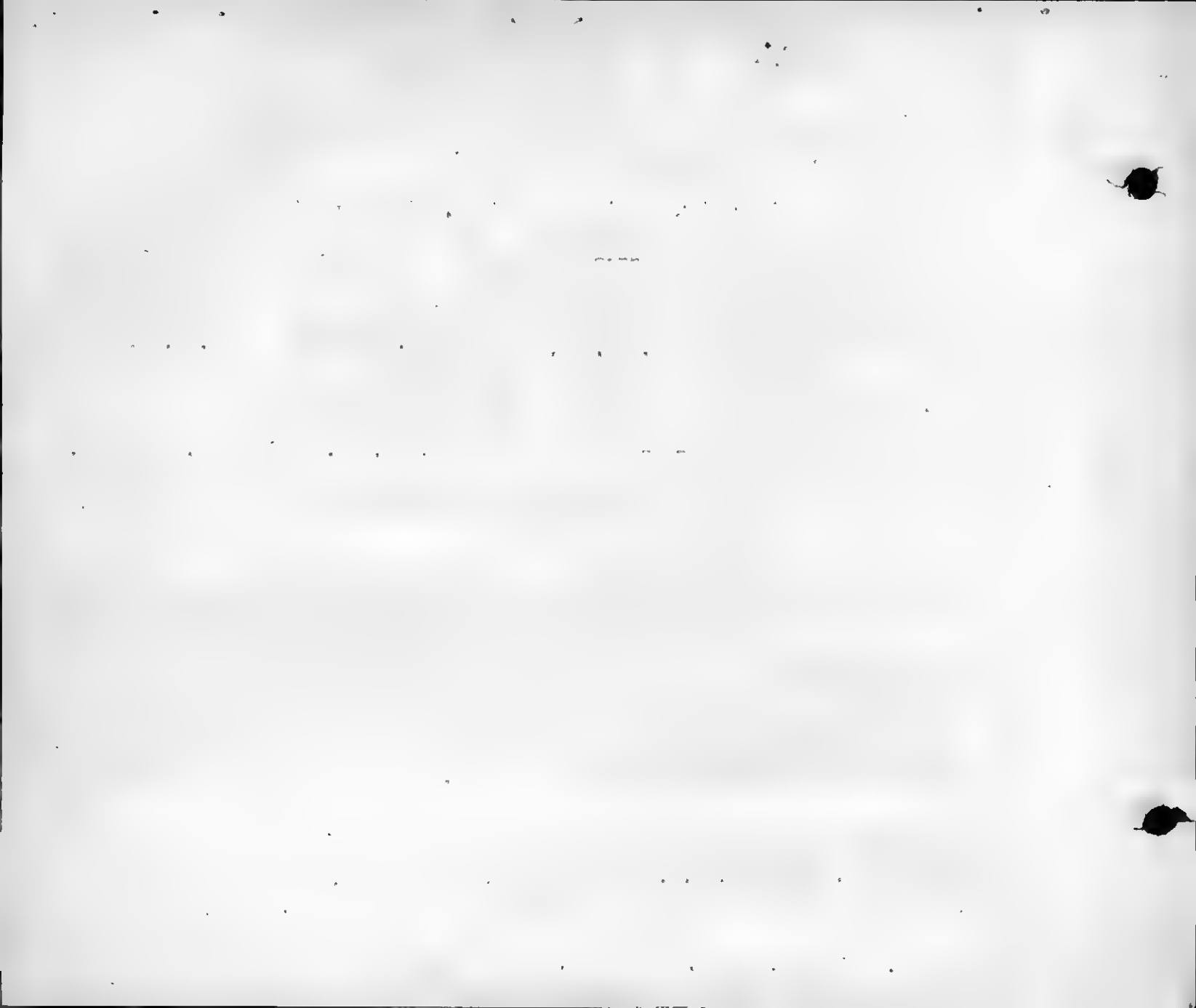
MEDICAL CERTIFICATION

2

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12

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8896

## CERTIFICATE OF DEATH

Reg. Dist. No.

08867

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <u>Ma</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>TOWSON</u>	c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>TOWSON</u>	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <u>611 Alleghany Ave</u>		d. STREET ADDRESS <u>611 Alleghany Ave</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM OLIVER SMITH JR</u>		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 30 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during day of working life, even if retired) <u>Clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Ma</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Ma</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm O Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Larimore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>?</u>	
17. INFORMANT <u>Mrs Bernard Schloss Stevenson</u>		Address <u>Ma</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE MYELOMA</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-31-59</u> 19 <u>59</u> to <u>8-12</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8-11-59</u> 19 <u>59</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Carlton L. Sexton</u> M.D.		PHYSICIAN'S NAME (Type) <u>CARLTON L. SEXTON</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 13/59</u>		22b. DATE THEREOF <u>Aug 13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arundel Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Ma</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Jenkins</u> ADDRESS <u>Amlo 4905 York</u>		24a. REC'D BY REGISTRAR <u>Aug 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8897

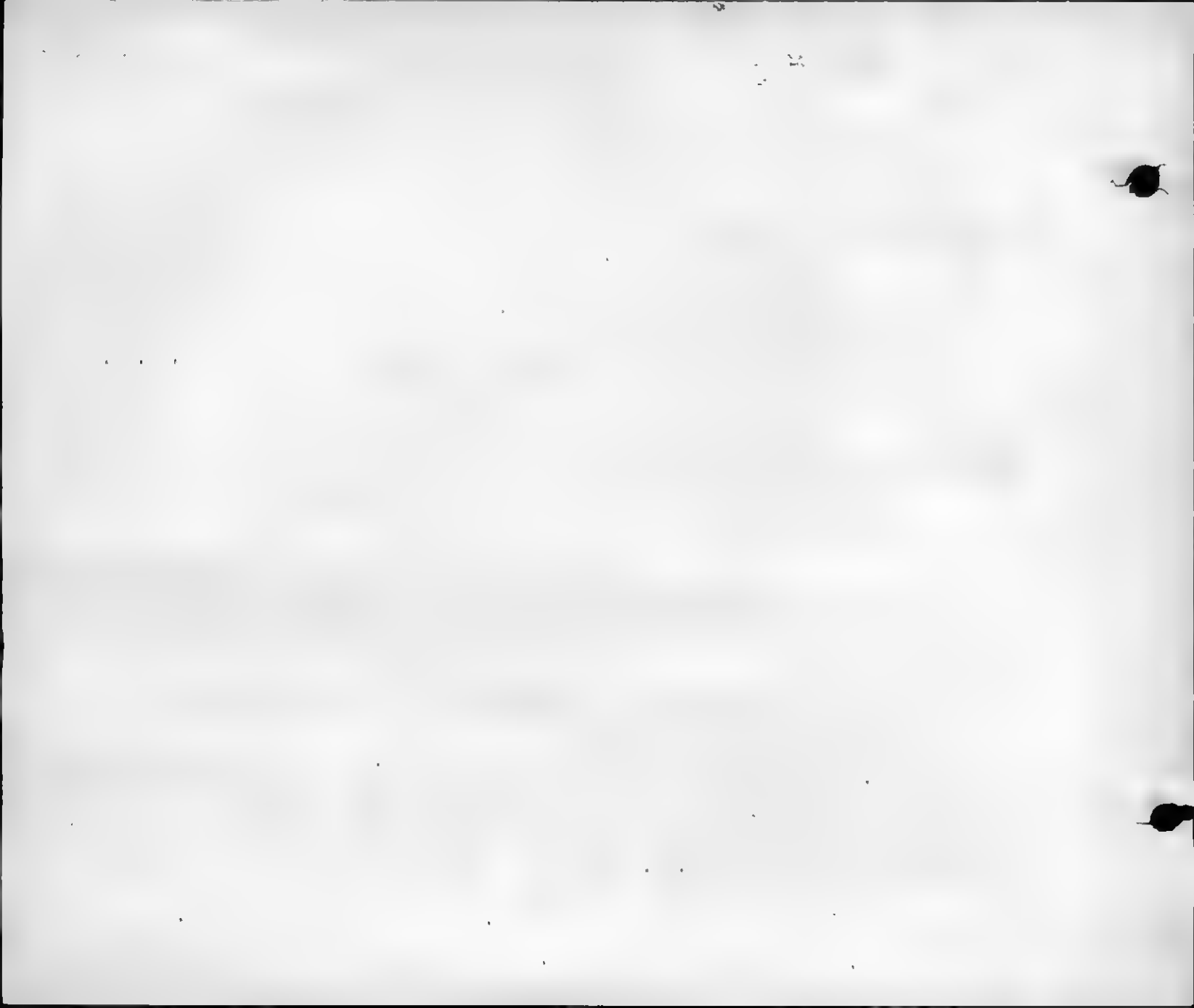
CERTIFICATE OF DEATH

08868

Reg. Dist. No.

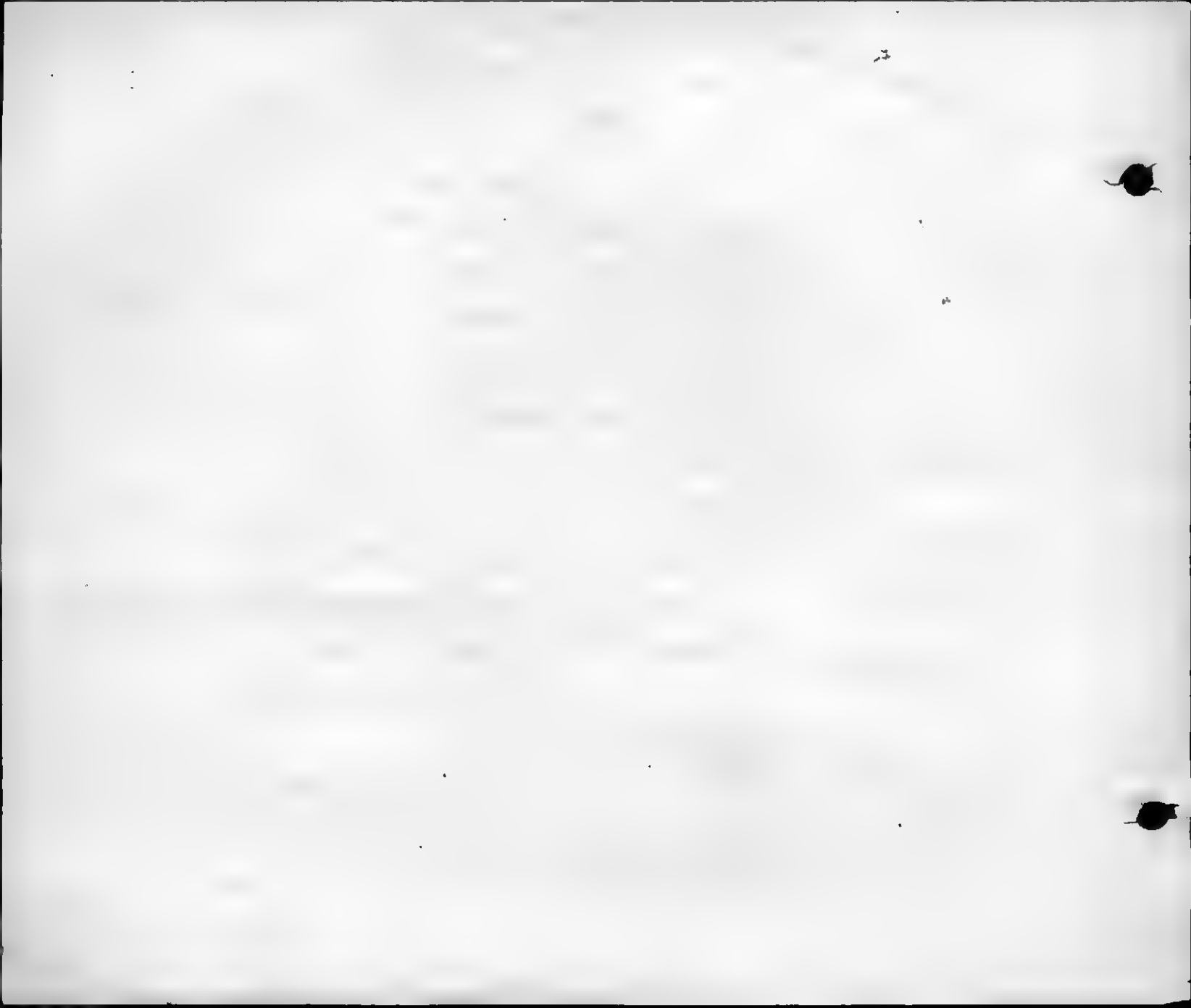
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13yr2mth5dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>T.</b> Last <b>Stamp</b>		4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>furniture finisher</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Stamp</b>		14. MOTHER'S MAIDEN NAME <b>Annie ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>216-12-5889</b>	
17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ulcer of stomach</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 22, 1959</b> , to <b>Aug. 26, 1959</b> , that I last saw the deceased alive on <b>Aug. 26, 1959</b> , and that death occurred at <b>1:15a M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 8-26-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>11y. 45d.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Stefanski</u> Middle <u>—</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>Germany</u>	
13. FATHER'S NAME <u>Matthias Stefanski</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna Lemensha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Records of Spring Grove St. Hosp.</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>a few weeks</u> <u>several years</u> <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of the right hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell on floor</u>	
20c. TIME OF INJURY, Month, Day, Year Hour a. m. <u>8:00</u> , <u>6/21</u> 1959 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>This hospital</u>		20f. (City or town) <u>Catonsville, Md</u> (County) (State)	
21. I certify that I attended the deceased from <u>June 30, 1953</u> , to <u>Aug. 15, 1959</u> , that I last saw the deceased alive on <u>Aug. 15, 1959</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>8/15/59</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAIUSKAS</u>		<u>Catonsville, Md</u>	
22a. BURIAL, CREMATION, DISPOSAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/26/59</u>	<u>Cathedral</u>	<u>1300 old Frederick Rd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley</u>		ADDRESS <u>1318 Light St</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

VS A15 (4)  
LSM 10/57



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VS A15 (4)  
15M 9/58

8899

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>LIFE</b>		d. STREET ADDRESS <b>1906 REDWOOD AVE.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1906 REDWOOD AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSALIE</b> Middle <b>A.</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 22-1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min <b>50</b>	11. IF UNDER 24 HRS Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AVON COSMETICS</b>	
11. BIRTHPLACE (State or foreign country) <b>BALT., CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NAYSMITH</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HOPKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-32-8991</b>	
17. INFORMANT <b>WALTER C. STEVENS</b>		Address <b>1906 REDWOOD AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2 Uremia</b> DUE TO (b) <b>Diffuse abdominal metastases</b> DUE TO (c) <b>Undifferentiated adenocarcinoma, primary</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 months</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/1/59</b> , 19 to <b>8/14/59</b> , 19 that I last saw the deceased alive on <b>8/14/59</b> , 19 and that death occurred at <b>8:16 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dick Van Beuren MD</b>		ADDRESS (Street, city or town, state) <b>MD</b>	
PHYSICIAN'S NAME (Type) <b>Dick Van Beuren MD</b>		DATE SIGNED <b>8/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-18-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GOVANS PRES. CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. P...</b>





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 2 Film G248 9-11-59 et

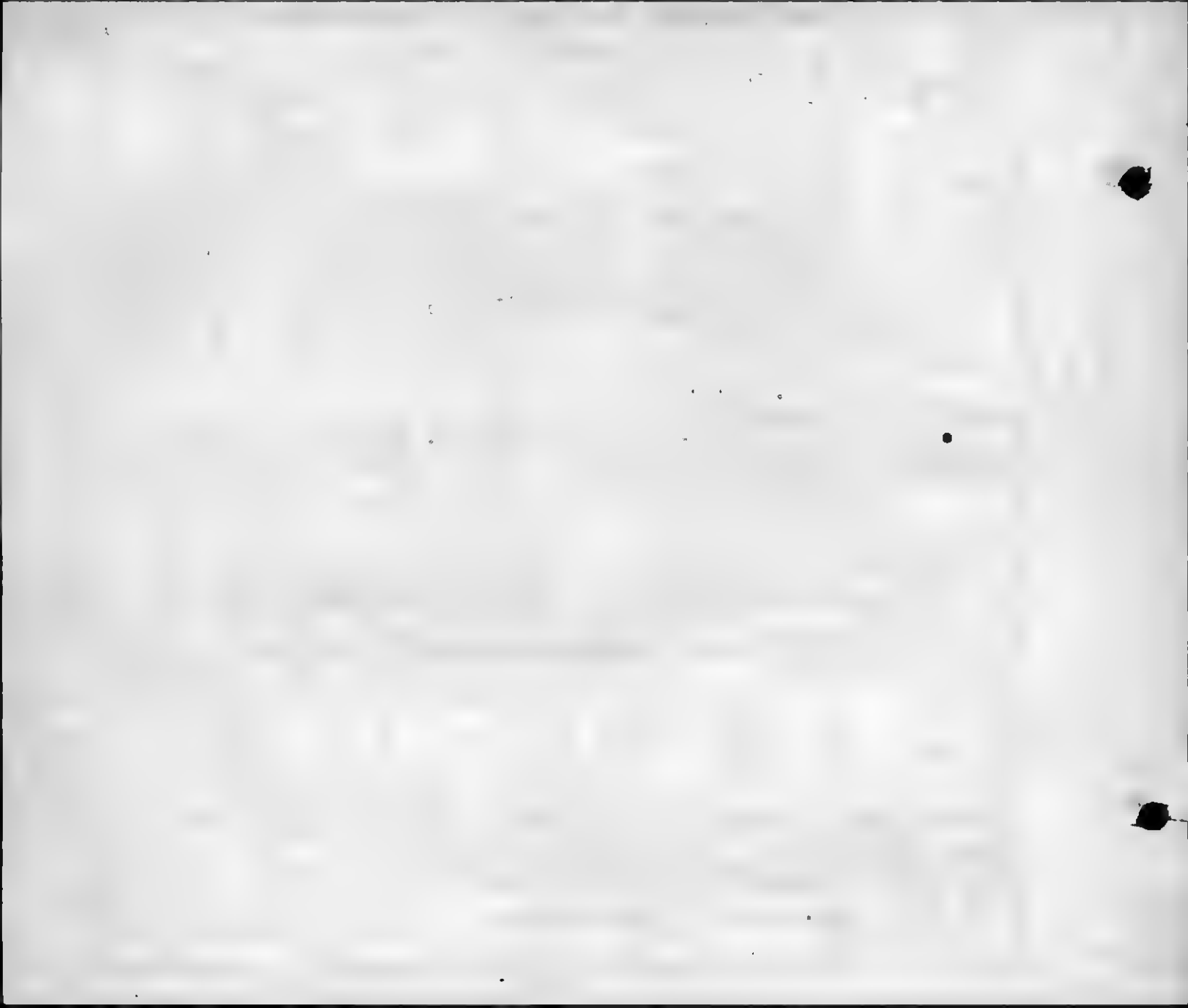
8900

CERTIFICATE OF DEATH

Reg. Dist. No.

08871

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Rural)</b>				c. LENGTH OF STAY IN 1b <b>Baltimore (Rural)</b> Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>				d. STREET ADDRESS <b>Harley Lane 9 Alston Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MINNIE AUGUSTA STIEFEL</b>				4. DATE OF DEATH <b>August 22, 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26, 1885</b>	
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR: Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min <b>74</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hamelil R. Hirschman</b>		14. MOTHER'S MAIDEN NAME <b>Ida Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-7827</b>		17. INFORMANT <b>Conrad E. Stiefel</b>		Address <b>9 Alston Rd. Lutherville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia Rt Base</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>ironition</b> (c) <b>aged - arteriosclerotic changes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13, 1937</b> to <b>7/22, 1959</b> , that I last saw the deceased alive on <b>7/17, 1959</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore 29 Md</b> DATE SIGNED <b>8/24/59</b>							
ACTUAL SIGNATURE <b>Cliff Ratliff Sr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF SR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc.</b> ADDRESS <b>1050 York Rd. Towson Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cliff E. Ratliff</b>	



8901

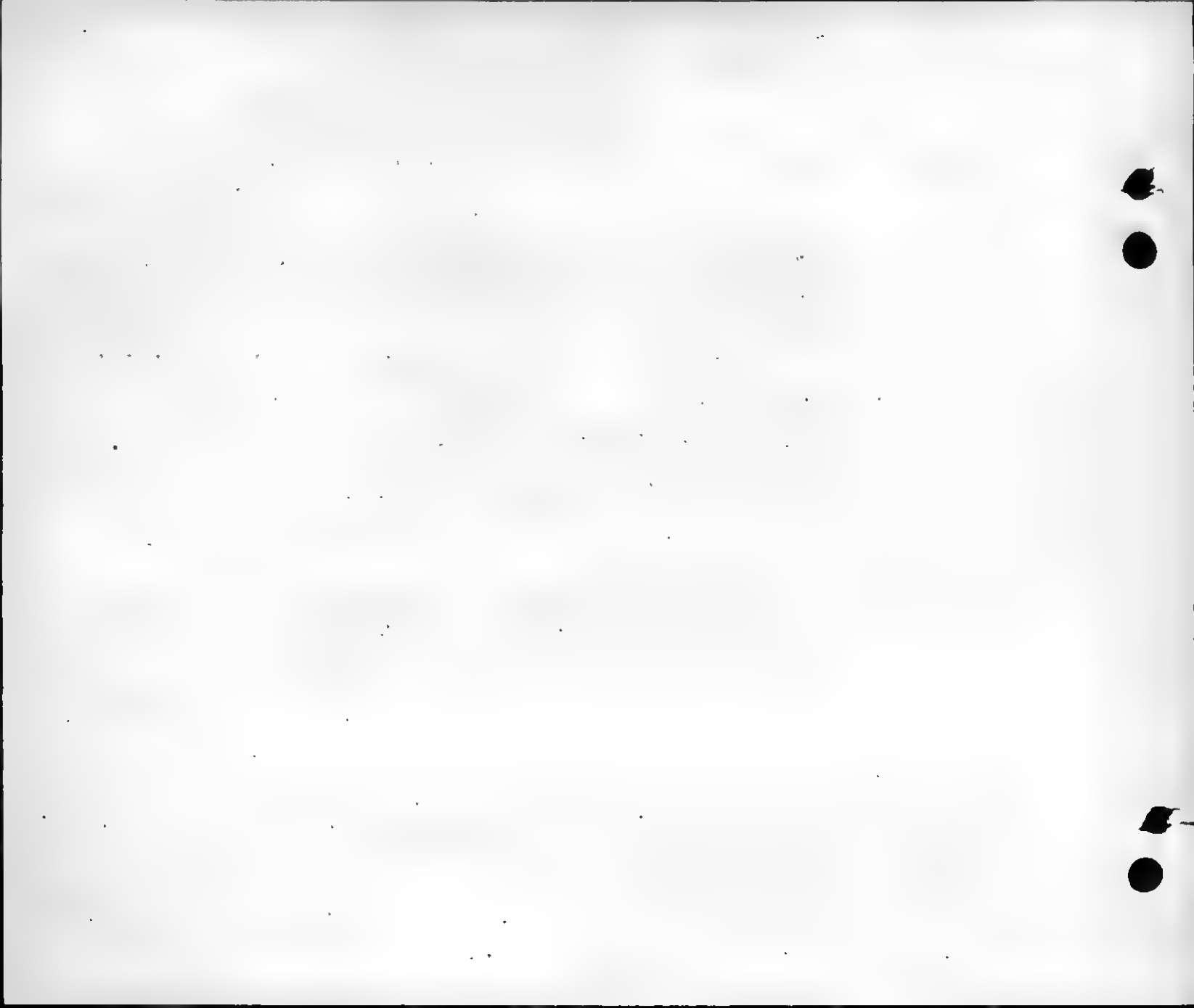
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton rural</b>		c. LENGTH OF STAY IN lb <b>18 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton rural</b>	
		f. STREET ADDRESS <b>Troyer Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Howard Swift</b>		4. DATE OF DEATH Month Day Year <b>Aug. 15 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Thomas Swift</b>		14. MOTHER'S MAIDEN NAME <b>Emma Louise Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-2685</b>	
17. ADDRESS <b>W. Lewis Swift</b>		18. ADDRESS <b>Monkton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Cardio Vascular Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure &amp; Pneumonia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:45 8-15 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Monkton</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I attended the deceased from <b>8-1</b> 19 <b>59</b> , to <b>8-15</b> 19 <b>59</b> , that I last saw the deceased alive on <b>8-15</b> 19 <b>59</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Herbert Mueller Jr.</b> M.D.		DATE SIGNED <b>8/15/59</b>	
PHYSICIAN'S NAME (Type) <b>C. HERBERT MUELLER, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Monkton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b>		24a. REC'D BY REGISTRAR <b>Charles E. Kurtz</b>	
ADDRESS <b>Jarrettsville Md.</b>		DATE <b>AUG 18 '59</b>	

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

8904

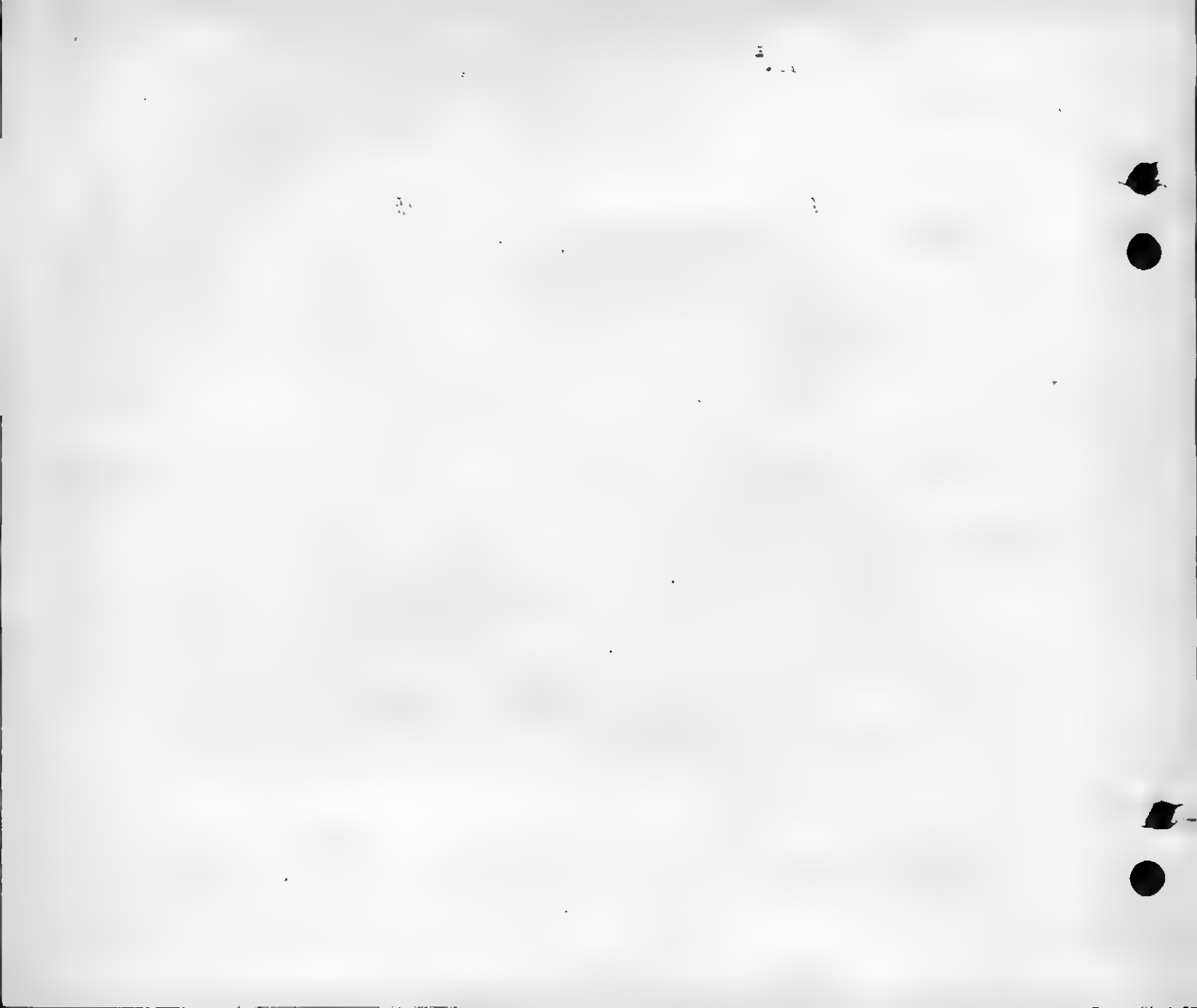
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAME AS D-C</u>		c. LENGTH OF STAY IN 1b <u>80 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>511 S. 45TH ST.</u>				d. STREET ADDRESS <u>511 S. 45TH ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TEENIE ANTOINA TADAJEWSKI</u>				4. DATE OF DEATH Month Day Year <u>9 - 13 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-1873</u>		9. AGE (in years and birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN KOZLOWSKI</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <input type="checkbox"/>		17. INFORMANT <u>HELEN KRIBS 511 S. 48TH ST.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-U Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERNICIOUS ANEMIA.</u> (c) <u>Senility -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>BALTIMORE</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/14/59</u>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter D. Brown 1001 Dunstable Ave</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grey Manor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grey Manor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1123 Old North Point Road</b>		d. STREET ADDRESS <b>1123 Old North Point Road</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE LAMBERT TATE</b>		4. DATE OF DEATH <b>August 7, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1883</b>
9. AGE (in years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Land scape gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Tate</b>		14. MOTHER'S MAIDEN NAME <b>Don't know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>212-26-3885</b>	
17. INFORMANT <b>Russell Tate 24 N. Kresson St.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-S-C-U-DISEASE</b> (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 12 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

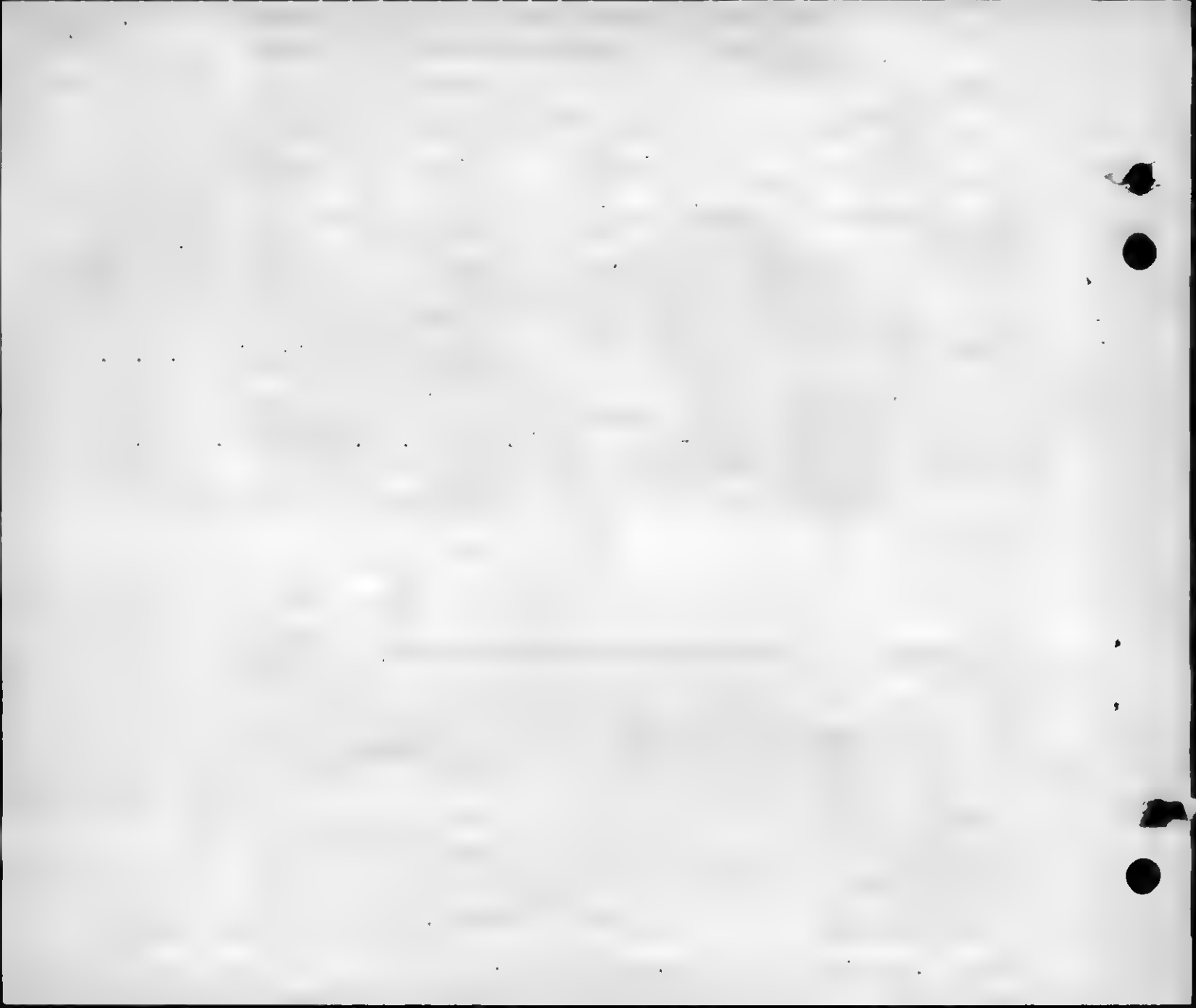




TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08874	
Item 18 Film 240 9-8903											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>370 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge (Baltimore 27)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>5448 Race Road</b>						
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>TAYLOR, JR.</b>					4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1959</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 7, 1909</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Handler</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Company</b>		11. BIRTHPLACE (State or foreign country) <b>Buffalo Springs, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Charles A. Taylor, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Nora M. Newton</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>			16. SOCIAL SECURITY NO. <b>215-14-8640</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>416X</b> <b>Rheumatic heart disease</b> IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr.</b>			<b>Aug. 12, 1959</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan, Jr.</b>					ADDRESS <b>1011 N. Arlington Ave.</b>		24a. REC'D BY REGISTRAR <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>		



08875

8905

# CERTIFICATE OF DEATH

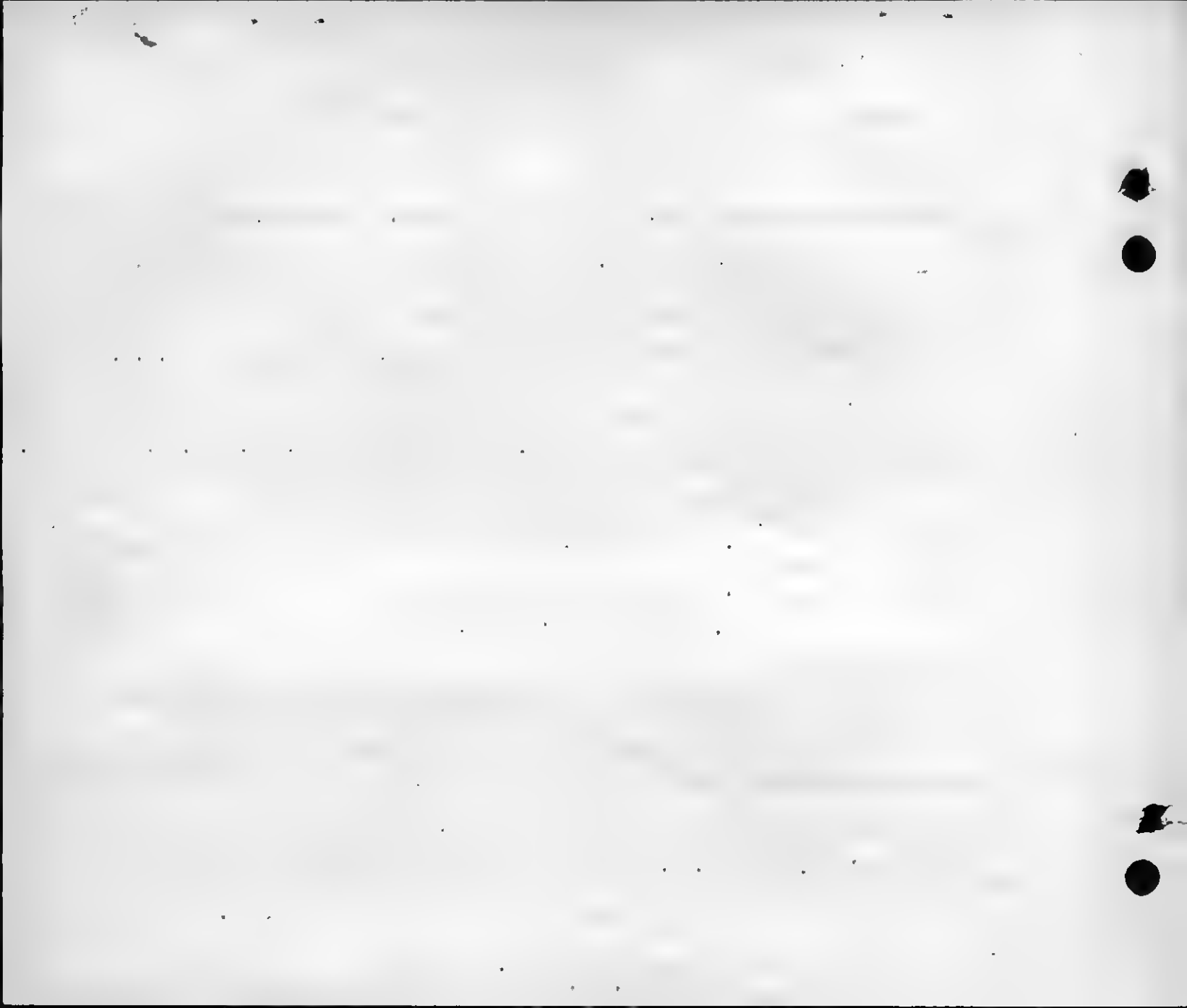
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1912 W. Lombard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>		Middle <b>#.</b>		Last <b>TAYLOR</b>	
4. DATE OF DEATH		Month <b>August</b>		Day <b>8,</b>		Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Uniontown, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWIN TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>MAY WARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WW I</b>		17. INFORMANT <b>CLIN. RECORDS FOLDER, VET. ADM. HOSP. FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PANCREATITIS</b> <b>DO NOT</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>2. PERICARDITIS, ACUTE</b> <b>DO NOT</b> (c) <b>3. ABSCESSSES OF LIVER AND KIDNEY</b>						INTERVAL BETWEEN ONSET AND DEATH <b>43 DAYS</b> <b>1 WEEK</b> <b>1 WEEK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4. MYOCARDIAL INFARCTION, ACUTE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>June 27</b> , 19 <b>59</b> , to <b>August 8</b> , 19 <b>59</b> . <del>He died on the date stated above.</del> and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. <b>6:15</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>CLYDE B COPE, M. D.</b> <b>VAH, FORT HOWARD, MARYLAND</b> <b>8/8/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M. D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight Ave</b> <b>Wm Cook Blight Funeral Home,</b>				ADDRESS <b>6009 Harford Rd.</b> <b>Balto. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3519 Sussex Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> d. STREET ADDRESS <b>3519 Sussex Road</b>		<input checked="" type="checkbox"/> IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Randolph</b> Last <b>Randolph</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25 1959</b>		9. AGE (In years last birthday) <b>21</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wash. D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Board of Child Care</b> Address <b>516 N. Charles St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/15/59</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 17, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	
22d. LOCATION (City, town, or county) <b>Dorsey</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Funeral Hom.</b>		ADDRESS <b>8728 Liberty Rd.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. H. King</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the reason therefor in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained in your files. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return them within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8907**  
**CERTIFICATE OF DEATH**

08878

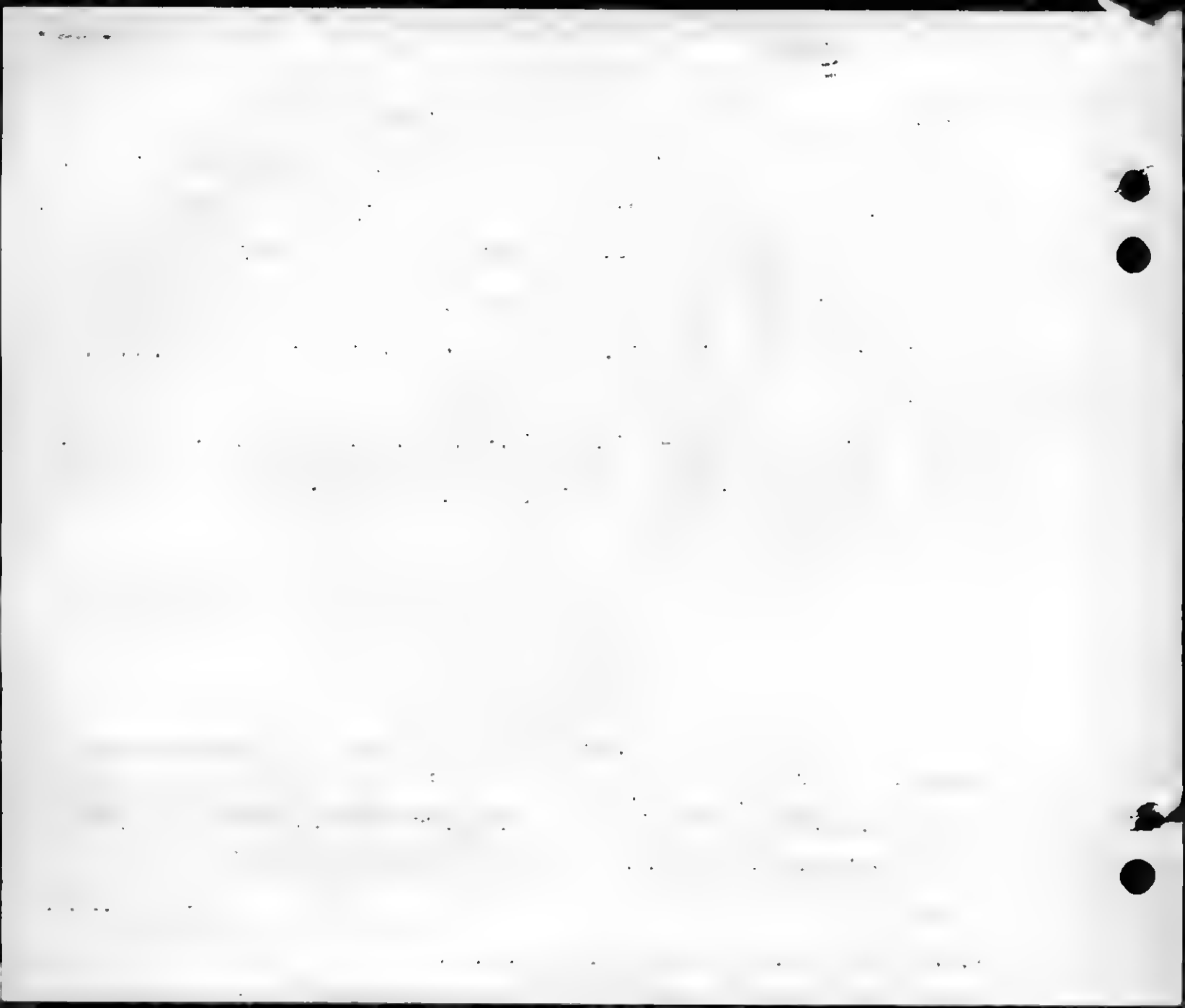
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>102 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>909 Woodlyn Road (21)</b>			
3. NAME OF DECEASED (Type or print) First <b>LEE</b> Middle <b>---</b> Last <b>TRIPLETT</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1925</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>		11. AGE (In years last birthday) <b>34</b> yrs.		12. IF UNDER 24 HRS Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Yacht Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Lenoir, North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joe Triplett</b>				14. MOTHER'S MAIDEN NAME <b>Lola Pope</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO. <b>243-22-8922</b>			
INFORMANT Address <b>Clin.Rec., Vet. Adm. Hospital, Fort Howard, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG, RIGHT, WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO (c) <b>---</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>---</b> p. m. <b>---</b> 19 <b>59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <del>I</del> attended the deceased from <b>April 27</b> , 19 <b>59</b> , to <b>August 7</b> , 19 <b>59</b> , and last saw the deceased <b>alive</b> and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>8/7/59</b>							
ACTUAL SIGNATURE <b>John W. Crawford</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		22d. LOCATION (City, town, or county) (State) <b>Caldwell Co., N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford R., Balto. 14, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

SHIPPED TO: Greer Funeral Home, 300 West Ave., Lenoir, N.C.

TO HUSBAND OF DECEASED: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908

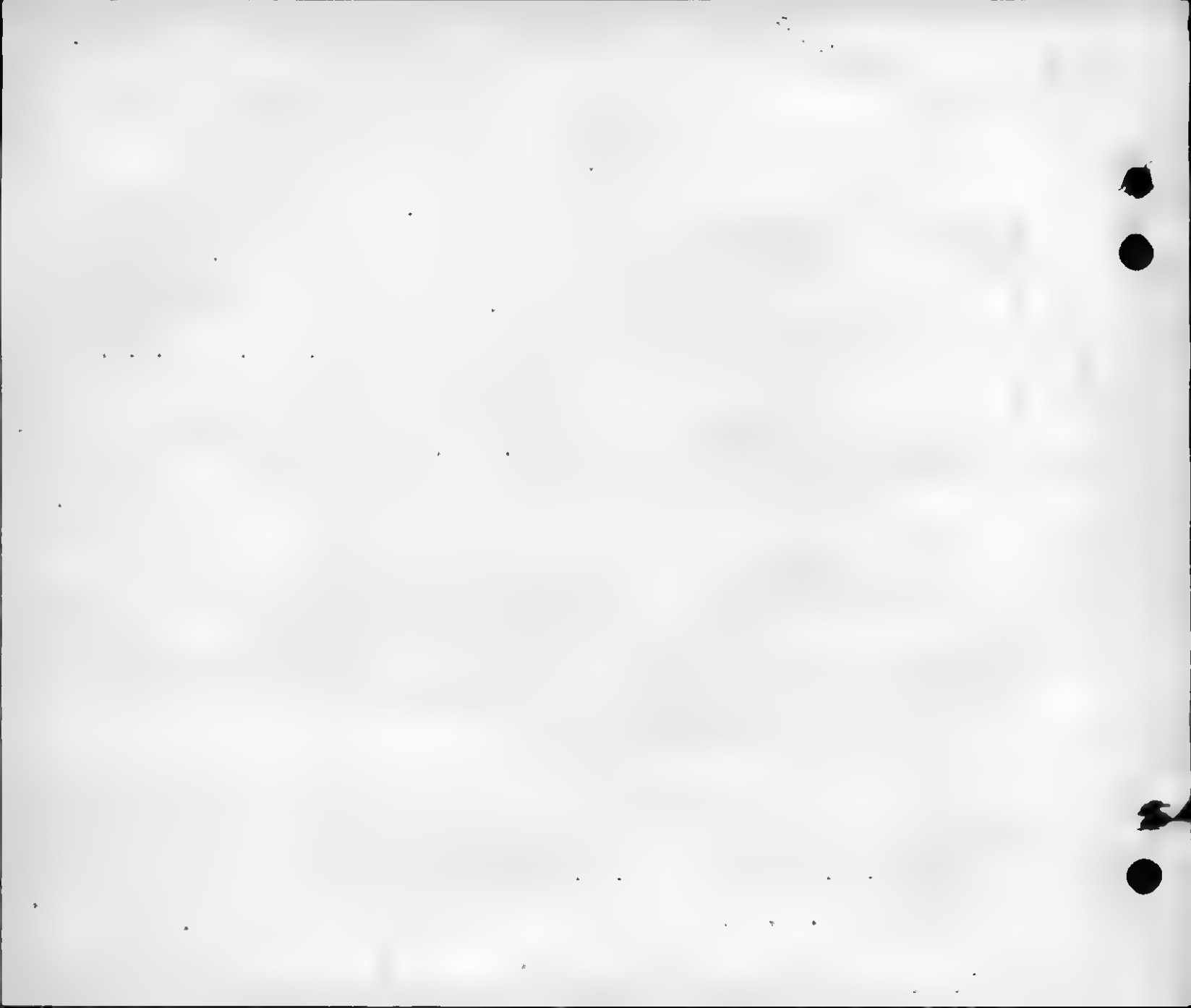
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		d. STREET ADDRESS <u>Rt. 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gwynbrook Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Virginia Turner</u>		4. DATE OF DEATH Month Day Year <u>Aug. 28 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Brown</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>174-20-2316</u>	
17. INFORMANT <u>Mrs. Robt. Tiedemann, Gwynbrook Lane,</u>		Address <u>Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>156.1</u> (c), stating the underlying cause last. DUE TO (c) <u>156.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>none</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. E. McWilliams</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. E. McWilliams, M. D. Acting</u>		DATE SIGNED <u>8-28-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 31, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friends Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Emmitsburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson</u>		24. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Emmitsburg, Md.</u>		DATE <u>AUG 31 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8909

## CERTIFICATE OF DEATH

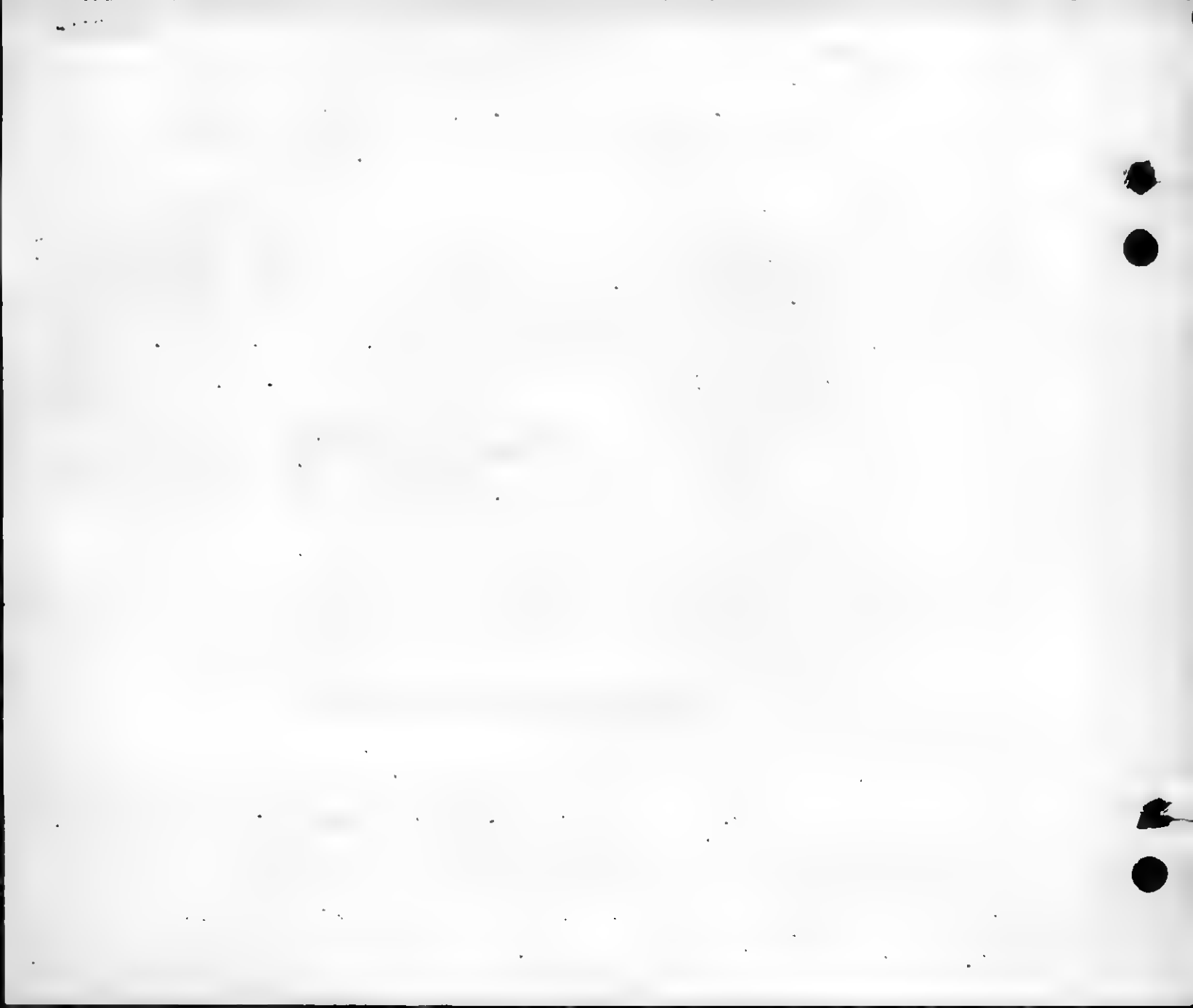
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>				d. STREET ADDRESS <u>none</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose</u> <u>Therrie</u>				4. DATE OF DEATH Month Day Year <u>Aug.</u> <u>12</u> <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894</u>	
9. AGE (Indicate last birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Goldberg</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Mitnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Charles Goldberg</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERNEPHROMA - LEFT WITH METASTASES</u> 1 x 3 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>1959</u> to <u>AUG.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2320 Eutaw Place</u> DATE SIGNED <u>8/13/59</u>							
ACTUAL SIGNATURE <u>Daniel Schwartz</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DANIEL SCHWARTZ</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Burial Ship</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Levinson</u>		ADDRESS <u>1124 W. North Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOWARD L. BENTLEY, M.D.: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be obtained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8910**  
**CERTIFICATE OF DEATH**

08881

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6901 Petworth Road</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6901 Petworth Road #12</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3 NAME OF DECEASED</b> (Type or print) <b>First HELEN Middle MARJORIE Last VERNAY</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>25</b> Year <b>19 59</b>									
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 23, 1894</b>		<b>9. AGE</b> (In years last birthday) <b>65</b> yrs <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"><b>IF UNDER 1 YEAR</b></td> <td style="width:33%;"><b>IF UNDER 24 HRS</b></td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min</td> </tr> </table>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS</b>	Months	Days	Hours	Min
<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS</b>										
Months	Days										
Hours	Min										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>George J. Fairbank</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Jessie G. White</b>								
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mr. Howard A. Vernay-6901 Petworth Road #12</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY</b>  <b>IMMEDIATE CAUSE (a)</b> <b>BIL. BRONCHO PNEUMONIA &amp; PLEURAL EFFUSION</b>  <b>491X</b> DUE TO  <b>CHC. ATROPHIC ARTHRITIS</b>  <b>30 YRS</b>  <b>3 YRS</b>  <b>30 YRS</b> </td> <td style="width:20%; vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 YRS</b>  <b>30 YRS</b>  <b>30 YRS</b> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b>  <b>(b)</b>  <b>(c)</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <b>BIL. BRONCHO PNEUMONIA &amp; PLEURAL EFFUSION</b> <b>491X</b> DUE TO <b>CHC. ATROPHIC ARTHRITIS</b> <b>30 YRS</b> <b>3 YRS</b> <b>30 YRS</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 YRS</b> <b>30 YRS</b> <b>30 YRS</b>	<b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b)</b> <b>(c)</b>			
<b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <b>BIL. BRONCHO PNEUMONIA &amp; PLEURAL EFFUSION</b> <b>491X</b> DUE TO <b>CHC. ATROPHIC ARTHRITIS</b> <b>30 YRS</b> <b>3 YRS</b> <b>30 YRS</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 YRS</b> <b>30 YRS</b> <b>30 YRS</b>										
<b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b)</b> <b>(c)</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <b>OCT. 1, 1937</b> , to <b>AUG. 25, 1959</b> , that I last saw the deceased alive on <b>AUG. 25, 1959</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above.											
<b>ACTUAL SIGNATURE</b> <b>Robert F. Healy, M. D.</b>		<b>ADDRESS</b> (Street, city or town, state) <b>301 MED. ARTS BLDG BALTO-1</b> <b>DATE SIGNED</b> <b>8/26/59</b>									
<b>PHYSICIAN'S NAME</b> (Type) <b>Robert F. Healy, M. D.</b>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8/28/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park Cemetery</b>							
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Wm J. Dickerson</b> <b>BALTO-17 Md</b>									
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AUG 27 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>C. L. K. K.</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8911

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Lanesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>Since 1950</u>				d. STREET ADDRESS <u>502 Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armstrong Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Taylor Vickers</u>				4. DATE OF DEATH Month Day Year <u>Aug-16-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-30-1865</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn NY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Heram S. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Provost</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Wm. H. Vickers</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastro intestinal hemorrhage</u> DUE TO <u>infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infection</u> DUE TO (c) <u>infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County) (State)			
21. I certify that I attended the deceased from <u>July 1958</u> , to <u>11/25/1959</u> that I last saw the deceased alive on <u>7/21/59</u> , 19 <u>59</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>11 E. Chase St., Balto. 2., Md.</u>				DATE SIGNED <u>11-25-59</u>			
ACTUAL SIGNATURE <u>Philip H. Whittlesey</u>				PHYSICIAN'S NAME (Type) <u>Dr. Philip Whittlesey</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug 18/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlough</u>				22d. LOCATION (City, town, or county) (State) <u>Balto 2-Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Hobbs</u>				24a. REC'D BY REGISTRAR <u>AUG 18 '59</u>			
ADDRESS <u>108 W. York - Balto.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

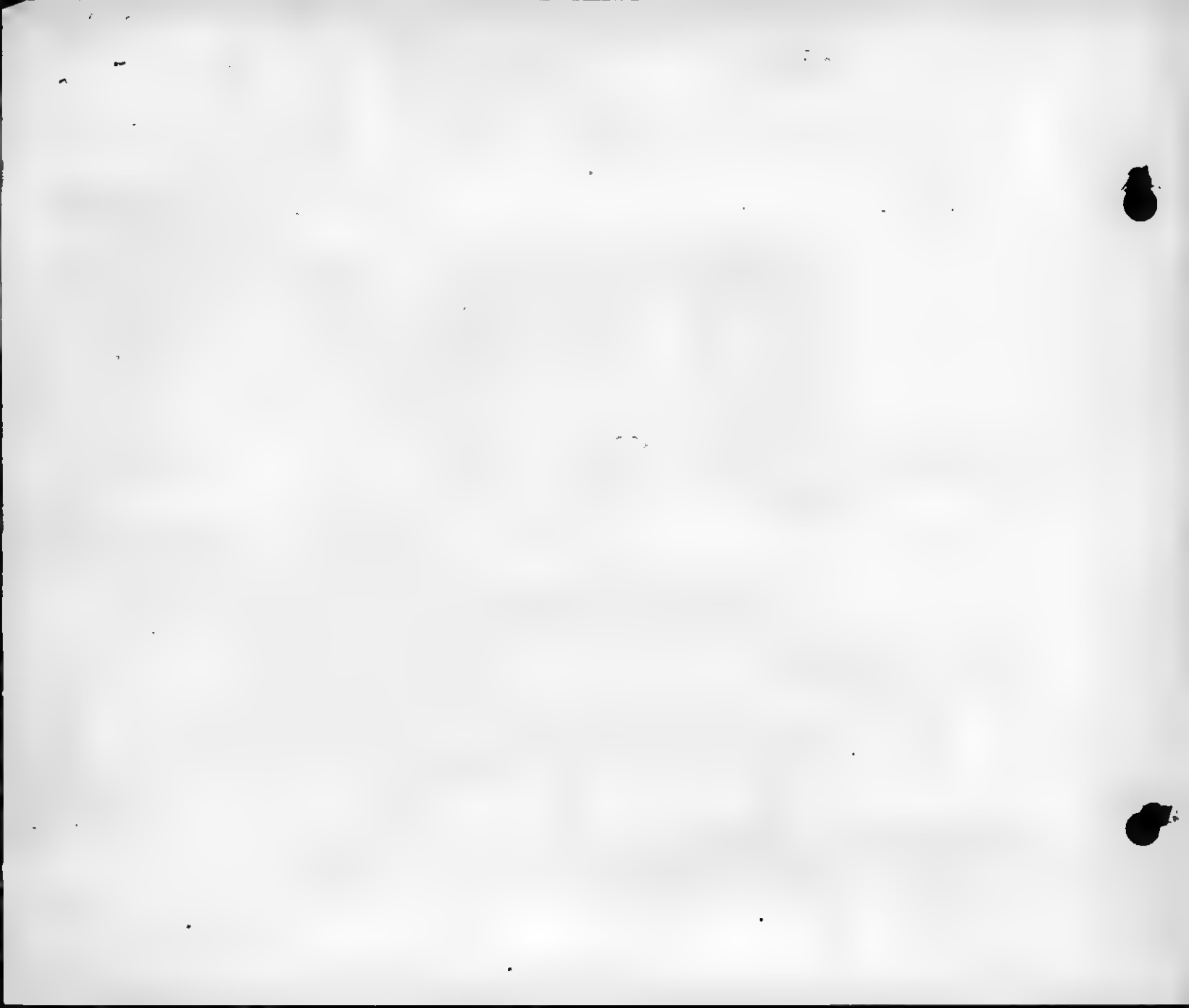
## 8912

### CERTIFICATE OF DEATH

08883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonridge Nursing Home</u>				d. STREET ADDRESS <u>#201 Cedar Drive, Marley Park</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>V.</u> Last <u>VOGEL</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Aug. 1882</u>		9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR: Months <u></u> Days <u></u>	IF UNDER 24 HRS: Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>(unknown) Wakeham</u>				14. MOTHER'S MAIDEN NAME <u>W. Virginia (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213123337</u>		17. INFORMANT Address <u>Mrs. Clara R. Potest Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left sided Cerebro Vascular accident 1 week ago</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 8, 1959</u> , to <u>7/27, 1959</u> , that I last saw the deceased alive on <u>8/25, 1959</u> , and that death occurred at <u>8:45 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4605 Edmond Ave</u> DATE SIGNED <u>8/27/59</u>			
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>				Baller <u>29, rd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>31 AUG. '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cen.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

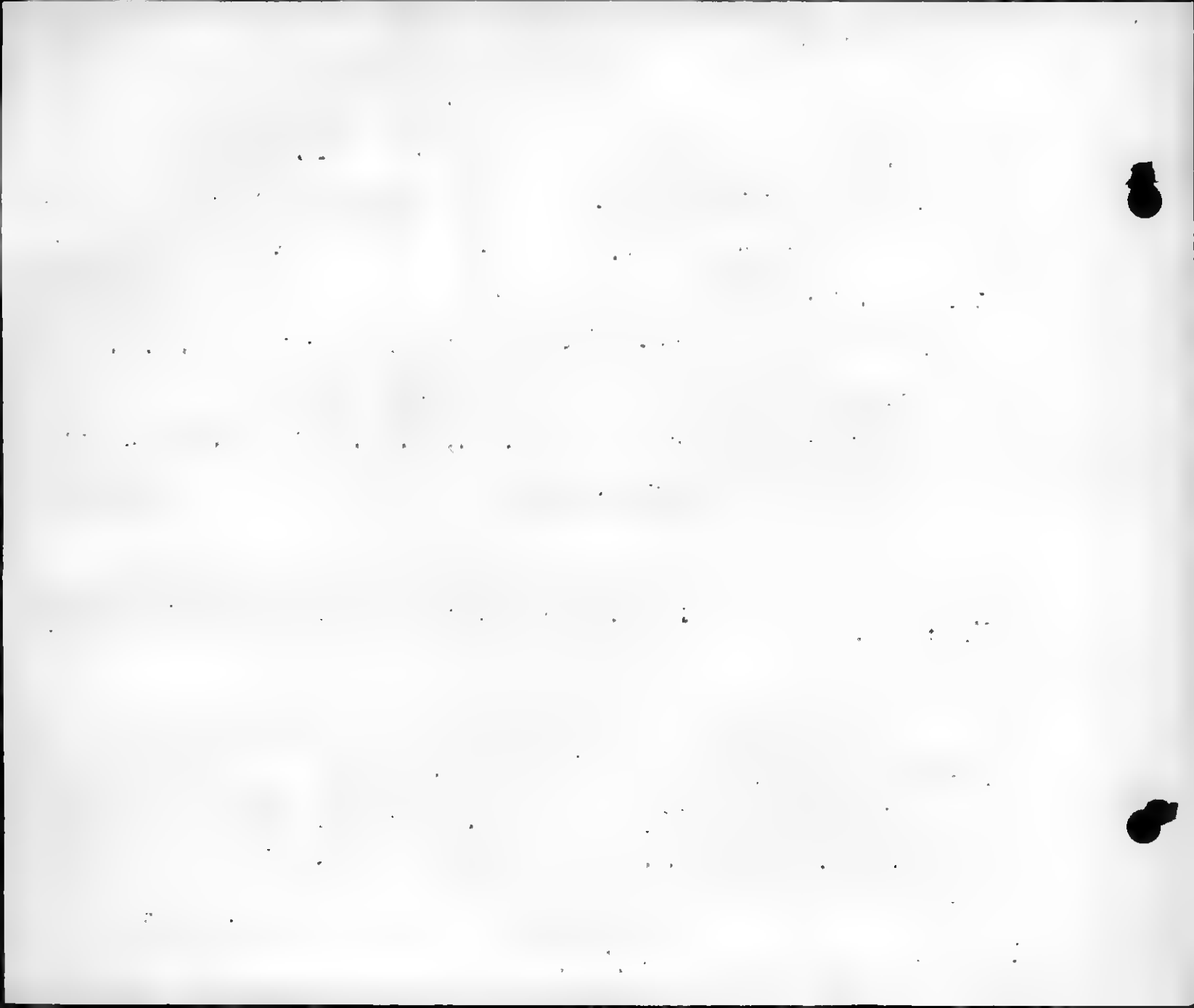
08884

8913

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>41 Days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1920 North Chester Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>A.</b> Last <b>VOGTMAN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 59</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1899</b>			
9. AGE (In years last birthday) <b>60</b> yrs		IF UNDER 1 YEAR Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Delivered farm produce</b>					
13. FATHER'S NAME <b>John Vogtman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Nordoff</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>					
17. ADDRESS <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO <b>CARCINOMA, RIGHT LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> DUE TO (c) <b>UNKNOWN</b>								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I (a) <b>1. Arteriosclerotic Heart Disease. 2. Osteo Arthritis. 3. Benign prostatic Hypertrophy.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>VA 19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>VA</b>				(County)		(State)			
21. I certify that I attended the deceased from <b>July 10, 1959</b> to <b>August 20, 1959</b> and that death occurred at <b>9:10 A.M.</b> from the causes on and on the date stated above.								ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>8/20/59</b>	
ACTUAL SIGNATURE <b>John W. Crawford</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				DATE SIGNED <b>8/20/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>				ADDRESS <b>3331 Brehms Lane Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 21 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

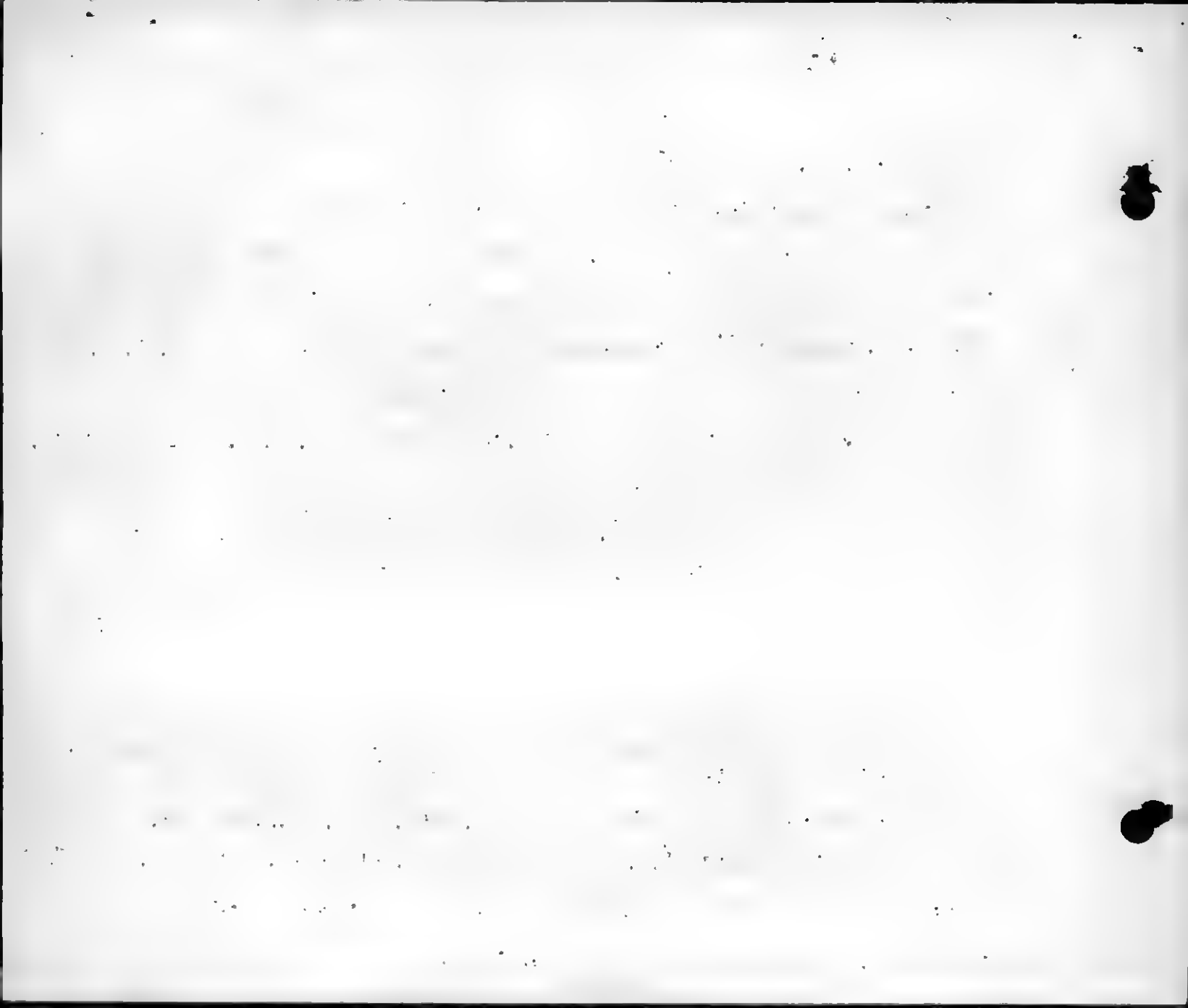


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8914**  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

08885

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>38 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>130 Aisquith Street</b> (2) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>W.</b> Last <b>WADDELL</b>			4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1899</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Power Mach. Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Customs House</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>George Waddell</b>				
14. MOTHER'S MAIDEN NAME <b>Anna Brummel</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				
16. SOCIAL SECURITY NO. <b>None</b>			INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>OBSTRUCTIVE JAUNDICE</b> DUE TO (b) <b>MASSIVE HEMATOMA, LIVER AND GALL BLADDER FOSSA ANEURYSMS, COMMON ILIACS AND RADIAL ARTERIES</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>UNKNOWN</b> <b>OLD</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTO. 18, MD., FT. HOWARD DIV.</b>			
20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>July 18</b> , 19 <b>59</b> to <b>August 25</b> , 19 <b>59</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clovis M. Snyder, M.D.</b>			ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD., FT. HOWARD DIV.</b>				
PHYSICIAN'S NAME (Type) <b>CLOVIS M. SNYDER, M.D.</b>			DATE SIGNED <b>8/25/59</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE</b>			
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>Md.</b>		22e. REC'D BY REGISTRAR <b>AUG 27 '59</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph J. Collick</b>			24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kenna</b>				



8915

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>702 OLD HOME ROAD</b>				d. STREET ADDRESS <b>702 OLD HOME ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>J. H.</b> Last <b>WALTER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1879</b>		9. AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BLACK &amp; DECKER CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-18-7353</b>		17. INFORMANT <b>EDWARD J. WALTER</b> Address <b>702 OLD HOME ROAD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>not determined</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 5, 1959</b> to <b>August 10, 1959</b> , that I last saw the deceased alive on <b>August 10, 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>6801 Belair Rd. Baltimore 6 Md</b> DATE SIGNED <b>8-12-59</b> ACTUAL SIGNATURE <b>Santi Amoroso</b> M.D. <b>6801 Belair Rd. Baltimore 6 Md</b> PHYSICIAN'S NAME (Type) <b>Santi Amoroso</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-14-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NAT'L CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Hone</b> ADDRESS <b>7401 Belair Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 14 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate must be completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL HOME: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

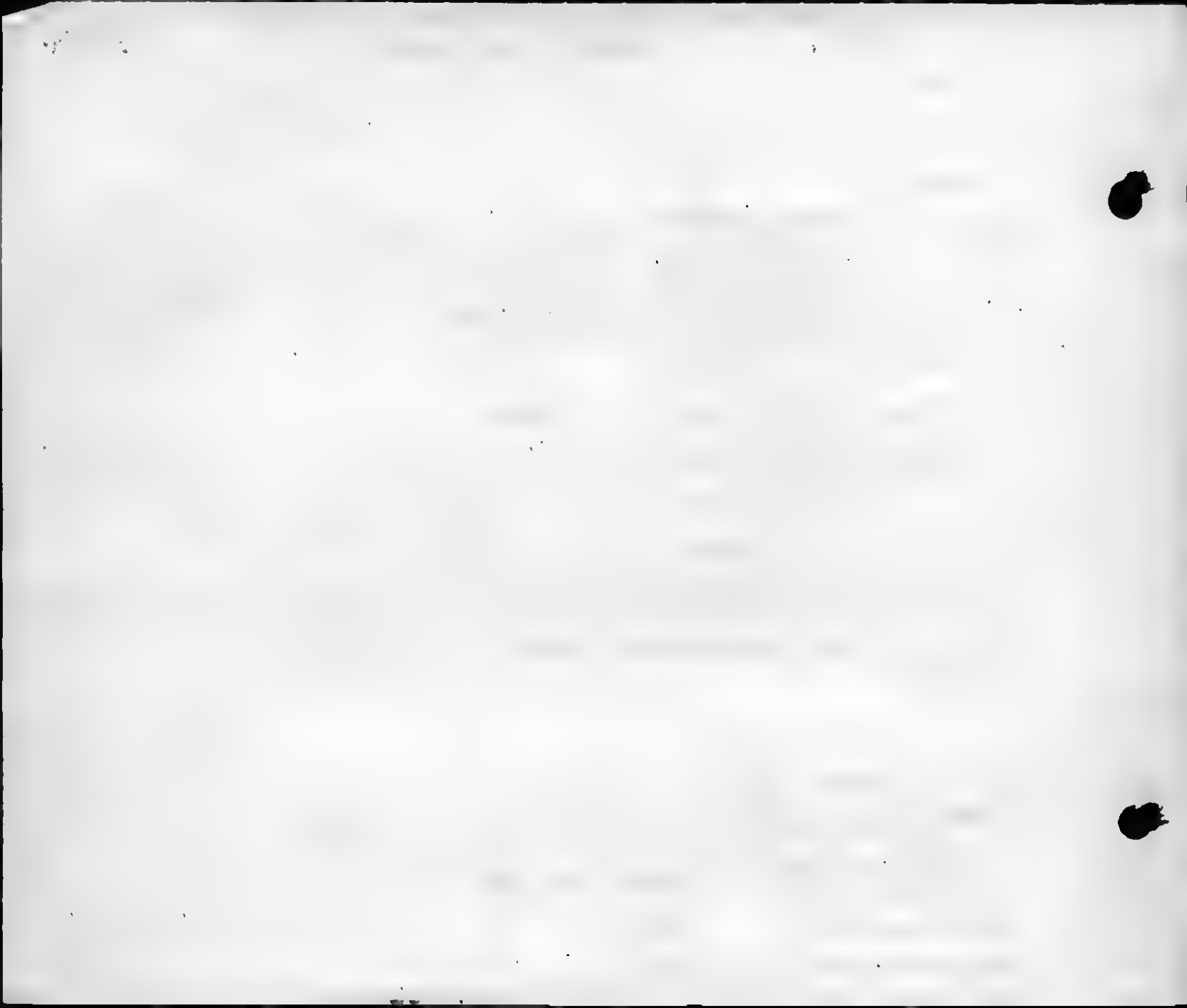
8916

## CERTIFICATE OF DEATH

08887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>555 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1811 Deveron Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>M.</u> Last <u>WARDELL</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Montrose, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry White</u>		14. MOTHER'S MAIDEN NAME <u>Anna Christian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Glenn Entrekin</u>		Address <u>1811 Deveron Road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO <u>LEFT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>VENTRICULAR FAILURE</u> DUE TO <u>RHEUMATIC VALVULAR DISEASE</u> (c) <u>RHEUMATIC VALVULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>2 MONTHS</u> <u>ONE YEAR OR MORE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>58</u> , to <u>8/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>59</u> , and that death occurred at <u>11:50 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald L. Somerville</u>		ADDRESS (Street, city or town, state) <u>25 West Pennsylvania Ave</u>	
PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE, MD</u>		DATE SIGNED <u>8/4/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moscow Cemetery</u>
22d. LOCATION (City, town, or county) <u>Lackawanna Co. Penna.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8917  
CERTIFICATE OF DEATH

08888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5911 Robindale Road		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md.		b. COUNTY Anne Arundel	
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS F. WASHENFELDT		4. DATE OF DEATH 8/20/59		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/79	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Alma Manuf. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Leo		14. MOTHER'S MAIDEN NAME Phillipine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 215 05 6367		17. INFORMANT Family - Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 to 1959, that I last saw the deceased alive on 12/18/79, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 8/25/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) (State) Baltimore		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Homes - 130 E. Fort Avenue		24a. REC'D BY REGISTRAR DATE AUG 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneas					



8918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>14 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>BURTONSVILLE 15<sup>th</sup></b>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>WARFIELD</b> Last <b>WATERS</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-31-1892</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MERCANTILE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>THOMAS WATERS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA DAWSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-83-8112</b>	
17. INFORMANT <b>Paul L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>vascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>59</b> , to <b>8-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-14</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D.		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>		DATE SIGNED <b>8/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks of Fairland</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

8919

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 Film 64-6 3-21-59 et  
CERTIFICATE OF DEATH

08890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-ROCKDALE</b>		c. LENGTH OF STAY IN 1b <b>6 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>friend's home 8311 LIBERTY Rd.</b>		e. STREET ADDRESS <b>6603 WINDSOR MILLS RD.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EMILY</b> Last <b>WEBER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 6/1895</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD COOMES</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE PEDICORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-28-3758</b>	
17. INFORMANT <b>SON - EDWARD WEBER</b>		Address <b>3524 STAMM RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Enteral Arterial Hemorrhage - Myocardial</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Coronary Artery Disease</b> DUE TO (c) <b>Coronary Insufficiency - Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>1 Year</b> <b>2 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 15, 1951</b> to <b>AUGUST 14, 1959</b> , that I last saw the deceased alive on <b>AUGUST 14, 1959</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD, BALTO, MD</b> DATE SIGNED <b>8/14/59</b>			
ACTUAL SIGNATURE <b>Edwin L. Pieppont</b> M.D.		PHYSICIAN'S NAME (Type) <b>EDWIN L. PIEPPONT, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b> ADDRESS <b>3707 W. North Ave</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Edwin L. Pieppont</b>			





8920

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>241 B. RODDERS FORGE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CLARENCE</u> Last <u>WERNETH</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHOTO-ENGRAVING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH JOHN SR. WERNETH</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH KOHLOPP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-2889</u>	
17. INFORMANT <u>FRANK L. WERNETH</u>		Address <u>2621 HILLCREST #14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		DATE SIGNED <u>8/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur &amp; Thomas</u>		ADDRESS <u>1212 E. ...</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8921

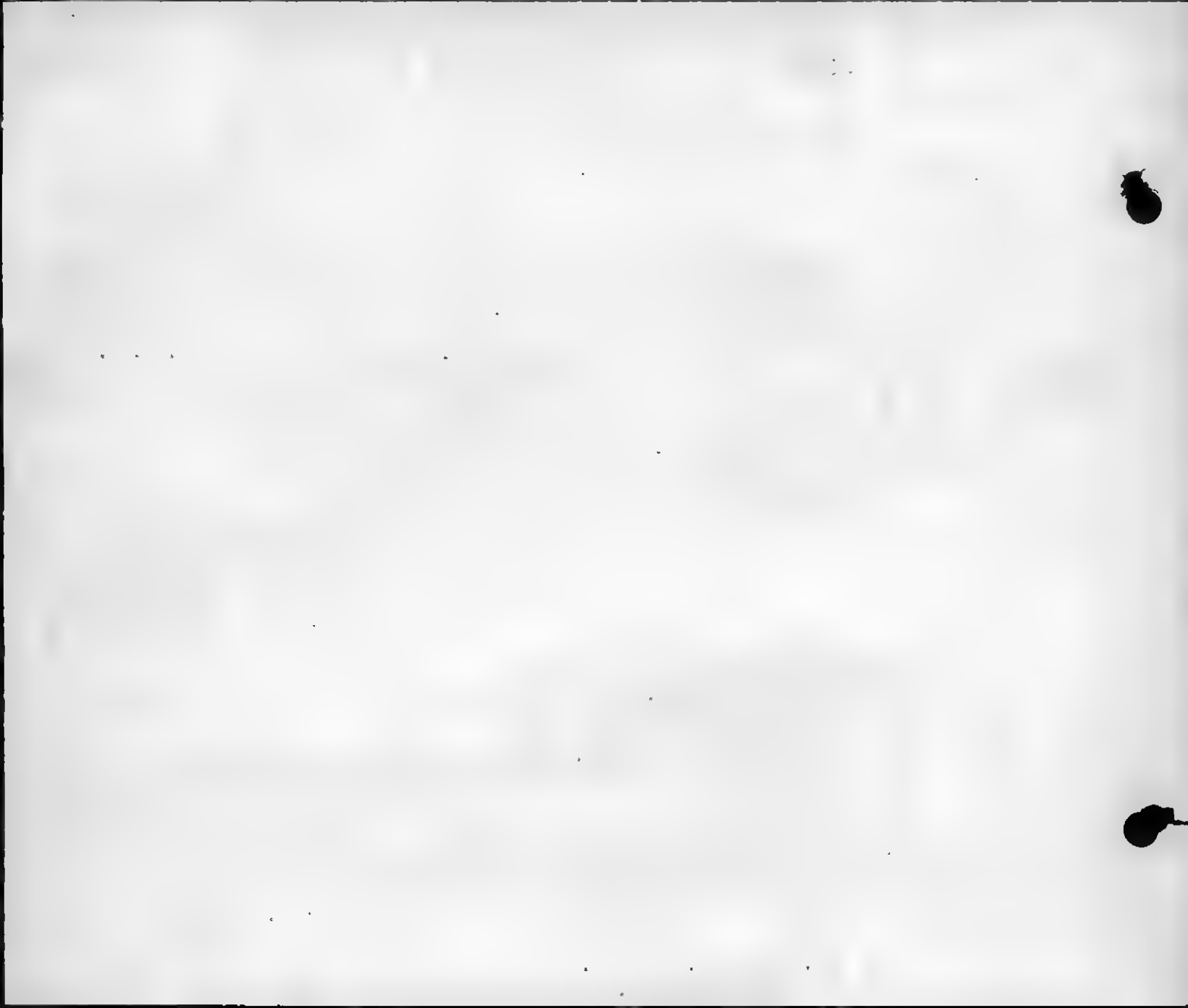
## CERTIFICATE OF DEATH

Reg. Dist. No.

08892

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Mary land</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr9mth21dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1802 Eutaw Place</b>	
3. NAME OF DECEASED (Type or print) <b>Frank</b> First <b>Oscar</b> Middle <b>White</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>(Unknown) George White</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Lydia Swan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 4. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anteriorleventic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 26</b> , 19 <b>56</b> , to <b>8/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/1</b> , 19 <b>59</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>8/1/59</b>	
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook Inc., 1217 St. Paul St., Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



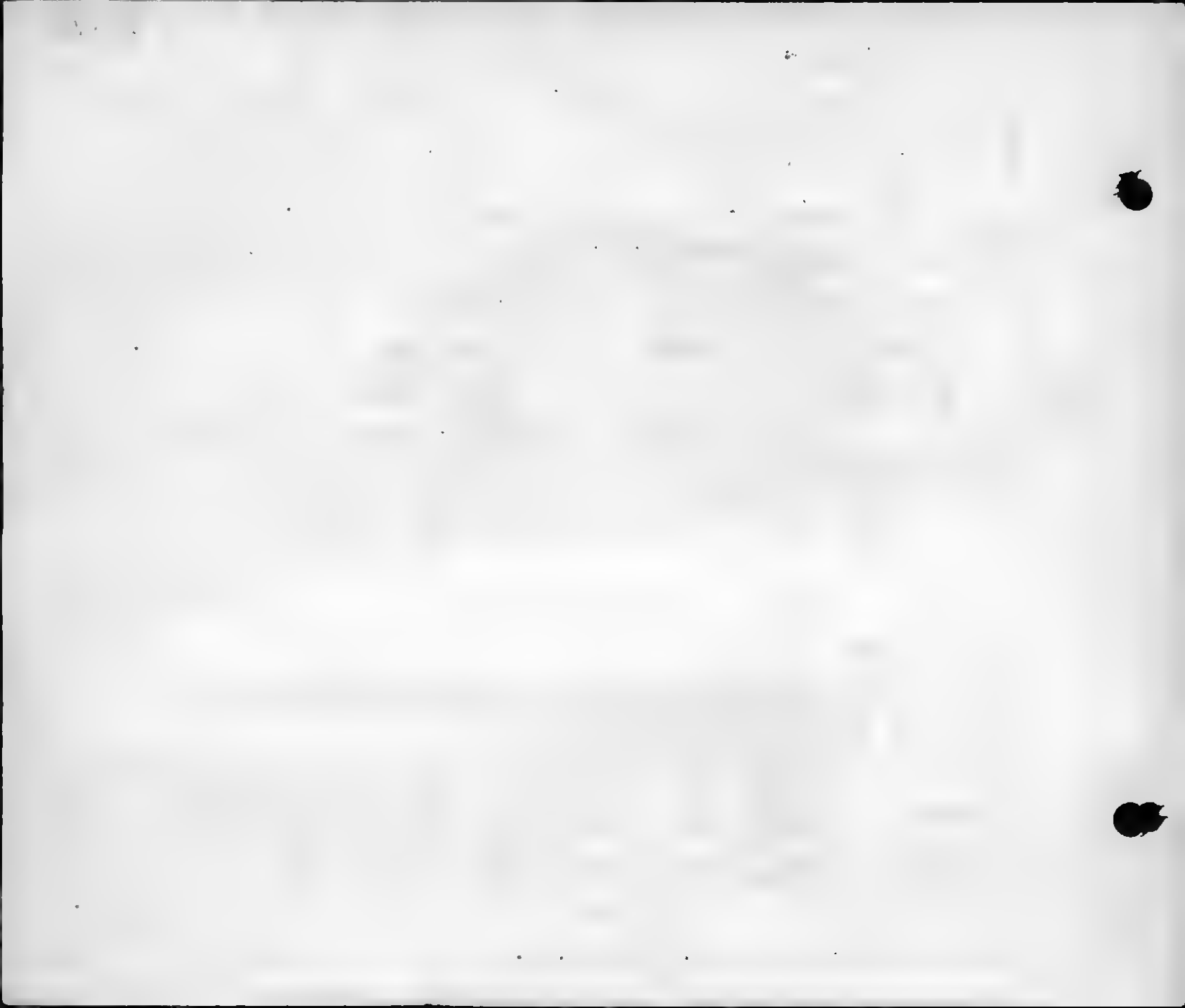
8922

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f. Institution Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore 14,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2434 Ellis Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Rosalee Wilkinson</b>		4. DATE OF DEATH Month Day Year <b>8-1-59 19</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1870</b>
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Staub</b>		14. MOTHER'S MAIDEN NAME <b>Mary Blondel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Estelle Wilkinson,</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/23</b> , 19 <b>58</b> , to <b>8/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/31</b> , 19 <b>59</b> , and that death occurred at <b>4:30</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Reiter</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3408 Windsor Ave Baltimore -16, Md. 8/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Reiter, MD</b>		<b>Baltimore -16, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 5 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8923

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr3mth25days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>August 28</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Conrad Ackerman</b>		14. MOTHER'S MAIDEN NAME <b>Anne Binggold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Records; spring GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3, 1954</b> , to <b>Aug. 28, 1959</b> , that I last saw the deceased alive on <b>Aug. 28, 1959</b> , and that death occurred at <b>11:12 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Wm. J. Carotano</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>A. J. CAROTANO</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Carotano</b>		ADDRESS <b>Balto - 17, Md</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 31 1959</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





08895

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>25 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4333 Ridge Ave.</u>		e. STREET ADDRESS <u>4333 Ridge Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Nettie Wisner</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24, 1899</u>
9. AGE (In years last birthday) <u>59</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Riggins</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-7743</u>	
17. INFORMANT <u>Harry Wisner</u>		Address <u>4333 Ridge Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive A. S. C. V. D. &amp;</u> 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary Edema</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/2</u> , 1959, to <u>8/23</u> , 1959, that I last saw the deceased alive on <u>8/22</u> , 1959, and that death occurred at <u>4:05 A.</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Halethorpe Md</u> DATE SIGNED <u>8/24/59</u> ACTUAL SIGNATURE <u>John C. Tracy</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Suburban Lane</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

**HOSPITAL CERTIFICATE OF DEATH:** The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 may be retained at the hospital or attending physician.

**ATTENDING PHYSICIAN:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8924

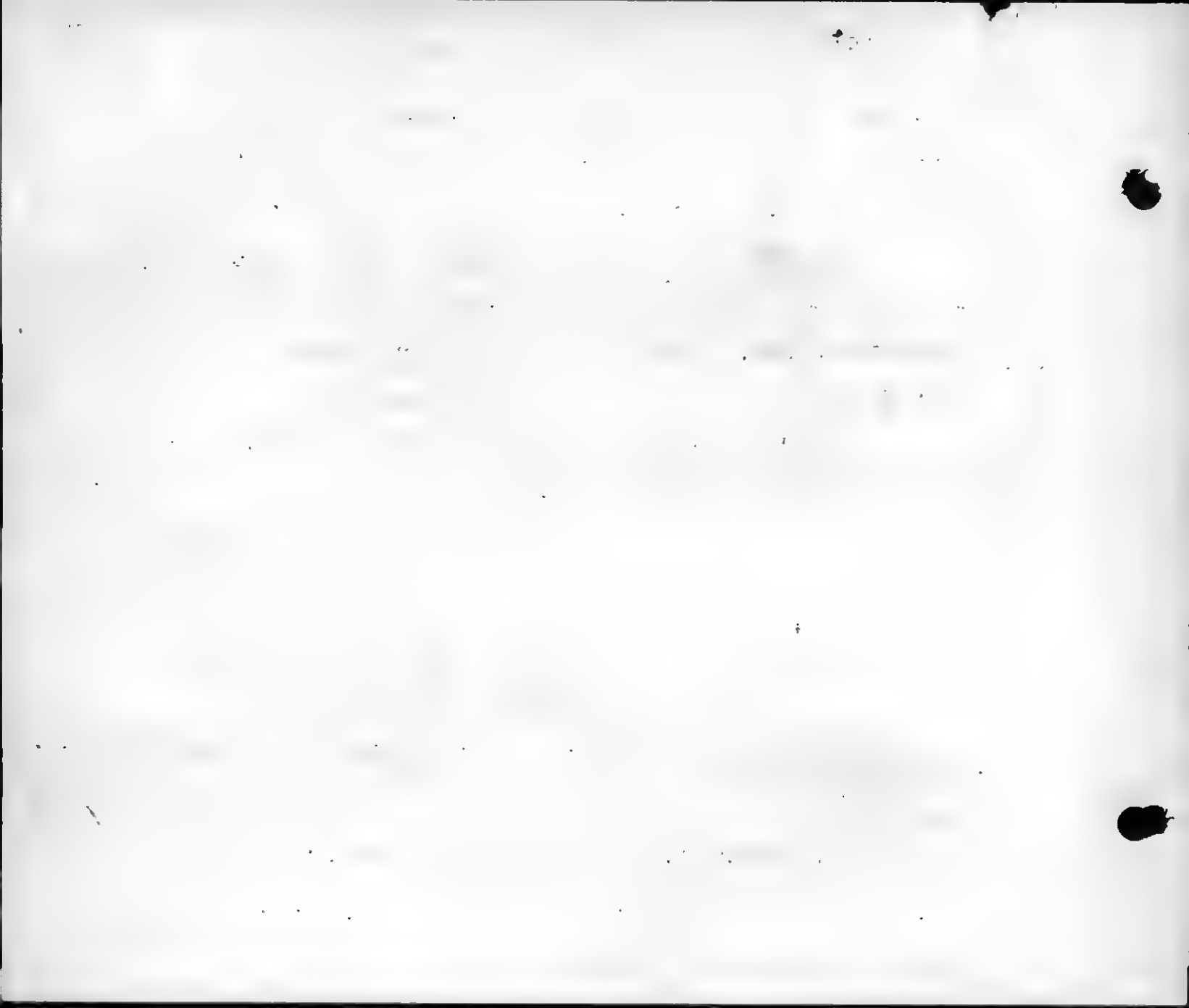
## CERTIFICATE OF DEATH

Reg. Dist. No.

08896

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>36 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>C</b> Last <b>WOODEN</b>			4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1887</b>		9. AGE (In years last birthday) <b>72 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Common Fireman, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S A</b>			13. FATHER'S NAME <b>Thomas Wooden</b>		
14. MOTHER'S MAIDEN NAME <b>Louise Harriman</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes NW I</b>		
16. SOCIAL SECURITY NO. <b>Unk 218-07-2391</b>			INFORMANT Address <b>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> <b>4.20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1959</b> to <b>August 7, 1959</b> , and that death occurred at <b>5:00A M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D.		ADDRESS (Street, city or town, state) <b>VAH FT HOWARD, MD</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>8/8/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cyach Funeral Home 901 N. Chester St. Balto. Md</b>		ADDRESS		DATE <b>AUG 11 '59</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

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8925

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b> c. LENGTH OF STAY IN 1b <b>Upperco</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hanover Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b> d. STREET ADDRESS <b>Hanover Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT YAREMA</b>		4. DATE OF DEATH <b>August 15 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIMON YAREMA</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>385-26-0270</b>	
17. INFORMANT <b>MRS. ROSE YAREMA</b>		Address <b>HANOVER RD UPPERCO MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>3:15 PM 8/15 19 59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Upperco</b> (County) <b>Balto.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>DETROIT MICH.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>		24a. REC'D BY REGISTRAR <b>418 Eastern Bldg.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>AUG 19 '59</b>	

100-100000

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

IN SENATE,  
January 10, 1900.

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE,  
MAY 1, 1899.

ALBANY: J. B. LEECH, STATE PRINTER.  
1900.

8926

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>	
c. LENGTH OF STAY IN 1b <b>10 Years</b>		d. STREET ADDRESS <b>7931 Shirley Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7931 Shirley Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Zaicko</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 13, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Zeiters</b>		14. MOTHER'S MAIDEN NAME <b>Mary Calender</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Doris Popowicz</b>		Address <b>7931 Shirley Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis - Diabetes Mellitus</b> DUE TO (c) <b>Chronic Bronchial Asthma</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>20 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN</b> , 19 <b>51</b> , to <b>AUG. 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/11</b> , 19 <b>59</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1515- MARTIN BLVD - BALTO, MD.</b> DATE SIGNED <b>8/21/59</b>			
ACTUAL SIGNATURE <b>Joseph J. Cameron</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOSEPH J. CAMERON</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 24, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc.,</b>		ADDRESS <b>1901 Eastern Avenue</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

